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ABSTRACT

Although the question of priority training needs for workers in British Columbia's (Canada) Alcohol and Drug Programs (ADP) direct service and funded agencies has been examined in the past, no prior needs assessment systematically surveyed workers in all job categories throughout the province. Results were obtained for administrators, program supervisors, health care workers, counselors, prevention workers, and office support workers. Respondents (n=149) completed a questionnaire which asked them to identify the tasks they performed in the domains of assessment, counseling, case management, education, and professional responsibility. Priority training needs were then determined for each group. The project team then examined the knowledge and skill components of those tasks for which at least one group identified a priority training need, and organized those components into educationally meaningful topic groupings. Respondents were a relatively educated group, with about three-quarters possessing at least a college certificate. Respondents were primarily concerned that training be accessible, pertinent and credible, and offered a wide range of recommendations. Contains 16 references. Appendices include the Questionnaire, Summary of Respondents' Self-ratings on Performance of Job Requirements, Component Analysis of Tasks Identified as High Priority Training Needs, and Focus Group Report. (JBJ)

Needs Assessment for

SUBSTANCE ABUSE TRAINING

Produced by

The University College of the Fraser Valley and

The University College of the Cariboo

for the

Province of British Columbia

Ministry of Skills, Training and Labour

Ministry of Health

and the

Centre for Curriculum and Professional Development

Substance Abuse Training Needs Assessment

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Executive Summary

Needs Assessment for Substance Abuse Training reports the results of an extensive process that was conducted in the Fall of 1993 and guided by a field-based, representative advisory committee. Although the question of priority training needs for workers in British Columbia's Alcohol and Drug Programs (ADP) direct service and funded agencies has been examined several times in the recent past, no prior needs assessment systematically surveyed workers in all job categories throughout the province. The study's findings were able to confirm and amplify much of what has been learned from previous assessments.

Results were obtained for administrators, program supervisors, health care workers, counsellors, prevention workers, and office support workers/office managers. Respondents completed a questionnaire which, among other things, asked them to identify the tasks they performed in the domains of assessment, counselling, case management, education, and professional responsibility. Priority training needs were determined for each group by identifying those tasks which the majority of its members report performing, and then ascertaining the gap between their self-rated current and desired levels of performance on those tasks.

The project team then examined the knowledge and skill components of those tasks for which at least one group identified a priority training need, and organized those components into educationally meaningful topic groupings which can provide a basis for developing or validating training.

Respondents were a relatively educated group, with about three quarters of them possessing at least a college certificate or diploma and 22% having completed at least some post-graduate work. Although some respondents were interested in training that would lead to credit for a certificate, diploma or degree, this was not the most attractive feature of potential training for any group. Rather, they were primarily concerned that training be accessible, pertinent and credible.

The report concludes with recommendations, which are given in summary form below:

1. That no more effort be expended on conducting needs analyses.

2. That significant resources be committed to *coordinated, provincial, in-service* training courses and programs which would be delivered on paid time, near the place of work (perhaps regionally), with costs, including employee replacement costs, subsidized by the employer.

3. That short term training efforts focus on:
   - individual, group, and family counselling skills
   - training in clinical supervision (for both supervisors and those supervised)
   - ethics and professional standards
   - methods to facilitate individual and group learning
   - working with multi-needs individuals

4. That an in-service professional development system be implemented which requires that professional development plans be filed annually by individual workers, and then commits funding that assists workers to address plans which are compatible with the goals of the organization and of the system of care.

5. That agencies be made accountable for the professional development funding they receive, and that they be required to spend a certain proportion of this funding on programs which bring the agency's employees together for training.

6. That ways be found to allow the employees who work together in an agency to have time for group professional development aimed at enhancing their ability to work together in treatment teams.

7. That the coordinated, provincial, in-service training strategy include sessions specifically designed to allow personnel from several local social service agencies to train together in order to enhance all parties' skills in working in multidisciplinary teams.

8. That creative methods of distance delivery form part of the training strategy, but only where appropriate to the content or objectives.

9. That an attempt be made to clarify the role of office workers and that appropriate training consistent with the tasks they are expected to perform be provided for them.

10. That a system of clinical (practical) supervision, by qualified supervisors, be implemented.

11. That individuals, organizations, and the system as a whole use the resources identified in *Inventory of Substance Abuse Training Resources* (companion publication to this one) to meet their training needs.

12. That a certification system similar to those systems used in education or nursing be implemented.

13. That the field's stated need for increased professionalism also be addressed by the Ministry of Health encouraging the Ministry of Skills, Training and Labour to fund pre-service certificate, diploma and degree programs for people who will work with clients who abuse substances.

Introduction

Project Background

In the summer of 1993, Alcohol and Drug Programs (ADP), British Columbia Ministry of Health, working through the Ministry of Skills, Training, and Labour (then the Ministry of Advanced Education, Training, and Technology) called for proposals to:

- develop an inventory of training activities and resources related to substance abuse, and
- conduct an analysis of priority training needs of alcohol and drug workers.

A joint proposal submitted by University College of the Fraser Valley and University College of the Cariboo was funded and the project team listed below started work on both components of the project on August 1, 1993.

Susan Witter	Dean of Continuing Education, University College of the Fraser Valley
Margaret Penney	M & W Penney and Associates Ltd.
Inga Thomson	Extension Coordinator, University College of the Cariboo
Gloria Wolfson	Program Head, Career/Continuing Education, UCFV
Deborah Block	Human Services Program, University College of the Fraser Valley

A Training Advisory Committee selected by ADP and chaired by Juanita Arthur (then Acting Area Manager, South Vancouver Island Area, Alcohol and Drug Programs) guided the project team in its work. Its members were:

Juanita Arthur	Project Coordinator/Acting ADP Area Manager, Victoria
Brian Butcher	Broadway Clinic, ADP, Vancouver
Helen De Groot	Phoenix Transition House, Prince George
Bill Downie	Alcohol and Drug Programs, Kelowna
Carol-Ann Dwyer	Campbell River Clinic, ADP, Campbell River
Reg Fleming	Day/Evening Youth Program, Victoria
Jeanne Harris	Dual Diagnosis, Greater Vancouver Mental Health Services
Elaine Hooper	Nechako Treatment Centre, Prince George
Roy Josephson	Maple Cottage Detox Centre, New Westminster
Patricia Lund	Aurora Society, Vancouver
Charlotte Mallory	Action A&D Counselling Society, Sechelt
Eleanor May	School Prevention Services, Vancouver
Sherry Mumford	Hope Alcohol and Drug Programs, Hope
Don Potkins	Maple Ridge Treatment Centre, Maple Ridge

The following Post Secondary and Ministry Representatives also assisted the Advisory Committee.

Dennis Anderson	Centre for Curriculum Development, Victoria
Jean Campbell	Ministry of Skills, Training and Labour, Victoria
Dr. Gordon Barnes	School of Child & Youth Care, University of Victoria
Marilyn McClaren	Vancouver Community College, King Edward Campus
Cindy Bettcher	Justice Institute, Vancouver

This report is the product of the second component of this project.

Scope and Limitations of the Study

This study was commissioned by Alcohol and Drug Programs (ADP), at that time a branch of the Ministry of Health. Its responsibilities included "planning, funding, and coordinating programs for the prevention of and treatment for alcohol and drug abuse in British Columbia". ADP was responsible for "direct services", those centres and services run directly by the government whose employees were considered public employees as well as for "funded agencies", those private, not-for-profit agencies that receive operating grants from ADP.

For the purposes of provision of services, ADP divided the province into five geographical regions:

Region 1 - **Lower Mainland** included Burnaby, Coquitlam, New Westminster, North and West Vancouver, Vancouver, Richmond and Sechelt.
Region 2 - **Fraser Valley** included Abbotsford, Chilliwack, Delta, Hope, Langley, Maple Ridge, Mission, Pitt Meadows, Surrey, and White Rock
Region 3 - **Thompson, Okanagan/Kootenays** included the area bounded by the American border to the south, the Alberta border to the east, just south of Williams Lake to the north and the Fraser Canyon to the west.
Region 4 - **North** included the area from Williams Lake north to the Yukon border, west to Prince Rupert, including the Queen Charlotte Islands
Region 5 - **Vancouver Island, Gulf Islands and the Central Coast** included Vancouver Island, the Gulf Islands and the Central Coast area.

Alcohol and drug workers employed by agencies funded by ADP (either direct service or funded agency) were considered the target group for data gathering. Agencies funded exclusively by the federal National Native Alcohol and Drug Abuse Programs (NNADAP) were not included.

Shortly after the project commenced, changes in the organizational structure of the Ministry of Health were announced. These changes had the effect of dissolving ADP as a separate unit. Its employees and its services are to be integrated into other services of the Ministry of Health in accordance with new directions being taken by the Ministry.

Although there is no longer a central agency responsible for implementing the recommendations of this study, we hope a mechanism will be found to move forward on these issues.

Definitions of Educational Terms

In any project of this sort, terms must be defined so that the researchers, the advisory committee, and the readers share a common frame of reference. The glossary below was developed for the purpose of this project.

Associate Degree - represents the completion of a prescribed two year program of studies that leads to an Associate in Arts or an Associate in Science. Can only be granted by community or university colleges which are accredited in British Columbia. In the Career-Technical areas, the equivalent in terms of achievement is still called a diploma although there is pressure to grant associate degrees in these areas.

Bachelors Degree - represents the completion of a four year course of studies (or 120) credits at an university or university college. Usually requires completion of a major (30 upper level credits) in a given field or two extended minors (usually 15-18 credits each).

Certificate - a college level program usually requiring the equivalent of 8 months full-time attendance at a post secondary institution. Usually expressed as a minimum number of credits, normally 30. It may also represent between 300 and 600 hours. This is not to be confused with a Continuing Education (C.E.) or Extension Certificate (see below) which tends to be for programs shorter than 300 hours.

Certificate of Attendance - usually given for a workshop or short course; simply reflects attendance rather than measured performance.

Certification - is usually used in one of two ways:

- loosely to refer to a credential from an educational institution OR
- certification of competency by a process of professional validation by one's peers or a professional association

Challenge - a system whereby students who believe that they have already mastered the skills and knowledge of a course apply for "challenge credit". Usually, they are required to write a challenge exam; they may have to complete assignments as well.

Citation - a designation used by some British Columbia colleges to recognize programs which are longer than 150 hours but shorter than a Certificate.

Competency Based Education - an approach to instruction in which curriculum is derived from an analysis of the job to be performed. Students are evaluated on their mastery of these competencies.

Continuing Education (C.E.) or Extension Certificate - usually available for programs which are shorter than 300 hours but longer than 150 hours.

Course - a learning experience, usually representing 30 to 60 hours in the classroom and requiring extensive learning outside the classroom and demonstrated mastery of concepts. Usually delivered over several weeks or months.

Credit - a system whereby credits are assigned for units of classroom time. One credit usually reflects 15 hours of classroom learning. Credit courses invariably require that the student demonstrate his/her achievement; grades are usually assigned.

Diploma - a college level program of 4 - 6 four month semesters, or 1200 - 1800 hours or 60 - 90 credits.

Distance Education - a format by which a student takes a course without being in the classroom. Includes course readings, assignments, may include tele-conferencing, video-conferencing, and/or discussions by telephone with tutors. Course packages with a great deal of detail are usually included as students work through the material on their own with occasional consultation with a tutor.

Doctoral Degree (Ph.D) - usually requires an additional one to three years of full-time studies after completion of a Master's degree. Will require a comprehensive examination as well as a dissertation which consists of original research and is defended before a committee of scholars.

Full-time - refers to a student who takes 600 hours of instruction over an 8 month period. Also may refer to a student who takes 60% of what would be a full-time load in that program. As well, there are programs which may only be done full-time (i.e. are not offered to the part-time student) and there are students who may be part-time in full time programs.

Inservice - learning activities, undertaken after a job has been assumed, which assist the worker to gain greater competency in performing the duties associated with the job.

Master's Degree - requires the completion of one to two years of full-time studies (or 30 to 60 credits) after completion of a Bachelor's degree. Usually requires a thesis, project, and/or comprehensive exam. Studies are generally confined to an area of specialization.

Module - usually refers to a segment of a course which can be taken independently. Modules can be either self instructional (designed for direct use by the student in independent study) or for use by an instructor as a curriculum guide.

Non Credit - courses, modules, etc., which are taken by individuals for their personal or professional benefit and not usually involving extensive testing or demonstration of mastery. Non credit courses may be offered not only by post-secondary institutions but also by school boards, private training institutions, and governmental or non-governmental organizations.

Part-time - a student who is usually engaged in activities other than attending classes and usually attends on less than a full-time basis. There may be part-time programs which are geared for these students or they may be part-time students in full-time programs.

Post Baccalaureate Diploma - usually requires the equivalent of 2 semesters full-time study (or 30 credits), after completion of a Bachelor's degree. of undergraduate work in an area other than the student's major and/or a more specialized area.

Preservice - those learning activities which train individuals to assume new job roles.

Prior Learning Assessment (PLA) - a system whereby potential students can receive credit for learning which has been obtained as the result of experience, self study, volunteer work, etc. Usually done on a course matching basis as the result of an extensive process of portfolio development where potential students examine their prior learning and career goals and match accomplishments with the course objectives for the course for which they wish to receive credit. A faculty assessor in the field then reviews the portfolio to make the decision whether or not to grant credit.

Program - an articulated set of courses or workshops with a coherent philosophy and learning objectives. Usually requires mastery of a set of learning objectives and has an outcome in terms of measurable learning. May be credit or non-credit.

Workshop - usually a one to three day concentrated learning experience focusing on experiential learning.

Review of Previous Work

Within British Columbia

Formal Studies

Coincident with British Columbia's *The Responsibility is Yours* (TRY) initiative in 1989, three localized needs assessment studies were commissioned by the Centre for Curriculum and Professional Development, acting on behalf of the Ministry of Advanced Education and the Alcohol and Drug Programs branch, then under the Ministry of Labour.

University of Victoria's Extension Department (reported by Alexander, 1989) conducted a two-day invitational seminar at Dunsmuir Lodge, including expert panel discussions, small group force-field analysis, and tele-conferencing. Unfortunately, it appears that only about half the participants were actual practitioners. The remainder were government officials and "experts" whose input may have strongly influenced the results. Findings indicated needs in the following areas:

Content: pharmacology; chemical dependency theories; research findings; new treatment models/strategies; special needs groups; ethical and legal standards; prevention models; adult development; family dynamics; health and wellness models; alternative models; spiritual issues.

Skills: counselling; communication; assessment interviews; community mobilization skills; intervention; prevention; marketing/promotion.

The attendees also made suggestions regarding the process and delivery of potential training. Preferences were for: practical and "longer" sessions; coaching with feedback; open learning; mediated learning; an integration of theoretical and practical learning; and both pre-service and in-service opportunities.

Key recommendations were for:

- cost-effective, regionalized training;
- quality control on materials and training programs;
- standard criteria for accreditation;
- multiple delivery systems; and
- increased funding.

Vancouver Community College (reported by Kroeker, 1989) conducted two mail surveys, one on distance education as a delivery method and the other on core curriculum.

For the distance education survey, questionnaires were mailed to "nurses and other health workers in hospitals, clinics, and care facilities; counsellors working in various alcohol and drug treatment units; Employee Assistance Programs (EAP); schools; and other social service units" in outlying areas. Details regarding sample selection and response rate were unclear. Findings were as follows:

1. Of respondents, 87% wanted distance education.
2. All suggested topics received high ratings: early identification; assessmer and referral; community resources; pharmacology; counselling skills; family and group dynamics; prevention; and practicum.
3. Additional topics suggested by respondents were: elderly clients; youth; natives; and co-dependents.
4. One to two day workshops and programmed self-learning were first choices for delivery.
5. Of the respondents, 52% wanted credit offerings; 88% would take non-credit offerings.
6. Of the respondents, 70% wanted courses in their home area; 25% were willing to travel.

For the core curriculum study, questionnaires were sent to: post-secondary institutions; hospitals; Ministry of Health coordinators; Ministry of Labour (ADP); EAP coordinators; private hospitals; Native bands; RCMP; and Department of National Defense (DND). In most cases these were sent to trainers, not practitioners. Again there was no indication of response rate. No course descriptions (just titles) were used on the questionnaire, which could have led to confusion on the part of respondents. Findings were:

1. Top priorities: fundamental concepts; symptom recognition; assessment and referral; and treatment resources.
2. Additional suggestions centred on the needs of special populations.
3. Workshops were the preferred method of delivery.

Douglas College (reported by Kissner, 1989) conducted a mail survey of 3300 professionals and paraprofessionals in health, education, justice, social work, and related fields, with a 20% return rate. Respondents were asked how frequently they performed a set of tasks, how confident they were in certain tasks, and in which areas they wanted more training. Respondents had an average of 12 years experience, and 85% of them worked directly with substance abusers. The sample was drawn from a mailing list of persons who had previously attended Douglas College courses.

Findings were:

1. Counselling, referral, and assessment were the respondents' high incidence tasks.
2. Respondents wanted more information/training on: counselling; treatment of others affected by the abuse; treatment of the substance abuser; assessment; teaching about substance abuse; prevention/public education; relapse prevention.
3. In knowledge areas, respondents had greatest confidence in causes of alcoholism, biological effects, and causes of abuse of other substances, and less confidence in their knowledge about psychological and social correlates of addiction, dependency processes, and biological effects of the abuse of other substances.
4. Respondents expressed most confidence in counselling skills (but less so in group and family counselling), identification of alcohol abuse, and identification of abuse of other substances, and less confidence in counselling groups associated with substance abuse.
5. Respondents were least confident working with various special groups.
6. Of respondents, 80% were willing to attend workshops/short courses.
7. The highest demand topics were: prevention; motivating abusers to seek treatment; constructive confrontation; and identifying abusers.
8. Of respondents, 33% were interested in home study/correspondence.
9. One to two day workshops at the end of the week were preferred.
10. Most respondents were unsure if they were interested in credit.

Less formal needs assessments were also done by Malaspina College and Fraser Valley College at this time.

A synthesis of these and other studies was done by ***Spectrum Consulting*** (reported by Long, 1989) in the document *Provincial Framework for the Training of Professionals and Paraprofessionals who work in the area of Substance Abuse*. Its purpose was to "develop a curriculum framework for the training of professionals and paraprofessionals in the substance abuse field within the post-secondary system" (p. 1). The document recommended a framework with detailed specification of content and skills organized into Basic, Advanced, and Specialized levels.

This framework was subsequently validated at a three-day seminar facilitated by the ***Open Learning Agency***. Participants were program developers from colleges and universities, with

some representatives from agencies and private consulting firms. The framework was validated, with some changes, and content areas were divided up for subsequent curriculum development work with different colleges taking the lead on each of the five areas: concepts; assessment and referral; issues; treatment; and counselling. This initiative resulted in five volumes of curriculum resources (see *Inventory of Substance Abuse Training Resources*).

At ***Forum '90***, a two-day invitational forum sponsored by the Ministry of Labour and Consumer Services March 29-30, 1990, mandatory pre-service and ongoing in-service training for "professionals in the area of substance abuse" was at the top of the list of recommendations.

In preparation for submitting a 1993 proposal to develop an educational framework for addiction services in British Columbia and at the request of Regions 1 and 2, the ***Justice Institute of B.C.*** conducted a needs assessment and developed a training plan (reported by Bettcher, 1992). With the assistance of an ADP staff-based training advisory committee, the author assessed needs of the four major classifications of employees: administrative support; detox workers; counsellors; and administrators/program directors.

In addition to basic clerical skills, the *administrative support* group was judged to be in need of:

- familiarity with basic concepts of substance abuse/addiction.
- familiarity with the system of care.
- ability to deal with angry/abusive clients.
- familiarity with basic counselling and crisis intervention.

Skills and knowledge items listed for the remaining groups were quite numerous. However, some summarization is possible. Both *counsellors* and *detox workers* needed:

- familiarity with cultural/social differences.
- ability to deal with specific populations.
- crisis intervention skills related to suicide and violent clients.
- ability to deal with dual diagnosis cases, including understanding of mental health disorders and relevant medications.
- various issues related to confidentiality, ethical standards, legal issues, and self care.

An additional area of need for *detox workers* was "knowledge about HIV and preventive strategies within detox."

Additional areas of need for *counsellors* were:

- advanced counselling skills.
- group and family counselling skills.
- youth/adolescent intervention skills.
- couple counselling skills.
- dealing with trauma and post-traumatic stress in relation to substance abuse.
- teaching/presentation skills.
- prevention skills.
- multicultural awareness and culturally sensitive counselling.
- transference/counter transference issues.
- stress management.
- time management.

Administrators/program directors shared many of the above needs, including:

- dealing with trauma and post-traumatic stress.
- dealing with dual diagnosis cases.
- prevention skills.
- multicultural awareness and culturally sensitive programming.

- stress management.
- time management.

Additional areas of need for *administrators/program directors* were the following:

- working with Boards and Board development.
- preparing grant applications.
- personnel management.
- ethical issues and standards.

Other Sources

In preparation for submitting an *Educational Framework for Alcohol and Drug Programs*, ***Spectrum Consulting*** (reported by Long, 1993) conducted telephone interviews with key informants, the results of which touch on the type of training they would like to see implemented. These results are informal, but comments indicated that the respondents favoured short courses/workshops and distance education (home study and correspondence) options. Respondents also argued for clinical supervision, a competency-based approach, financial rewards for attending training, paid leave of absence for training, the use of continuing education units as incentives, and the importance of integrating training with certification.

Another informal source of data comes from the evaluations completed by participants at the annual ***Pacific Institute on Addiction Studies***. These were provided in confidence to the researcher by Art Steinmann of the Alcohol - Drug Education Service. Only comments regarding suggested topics for future institutes were analyzed. Respondents indicated interest in the following topics: new treatment models; special needs groups; alternative models; spiritual issues; behavioral effects of drugs; cultural issues; native issues; sexual abuse; and FAS/FAE. They were also interested in the following skill areas: counselling; assessment; communication; community mobilization; prevention; relapse prevention; and working with multiple problem addicts.

Outside British Columbia

Studies from outside British Columbia show interesting similarities with the studies discussed above.

Armstrong, Boen, & Whalen (1978) asked twenty-six experts in the field to priorize a list of 12 "competencies" and indicate whether they should be learned in a formal academic setting or on the job. Although the so-called "competencies" were not all stated in true competency form, their intent seemed to be clear. The "competencies" were listed as follows:

Knowledge:

- physiological effects of drugs
- behavioral effects of drugs
- attitudes of non-abusers towards abusers
- counsellor's own attitude toward abusers
- symptoms of use and dependency
- legal and ethical standards
- community resources

Skills:

- one-to-one interviewing
- one-to-one counselling
- group counselling
- family interviewing
- family counselling

Only "physiological effects of drugs", "attitudes of non-abusers towards abusers", and "legal and ethical standards" received low ratings. The respondents favoured acquiring both knowledge and skills in a formal academic setting rather than on-the-job.

A different approach was adopted by ***Powell (1980)***, who studied one hundred practising counsellors. They were monitored and evaluated on a quarterly basis by twenty clinical supervisors over a two year period using a standardized rating scale. Results showed that over half the counsellors needed training in:

- assessment skills (including recognizing other behavioral/medical problems);
- listening, processing skills;
- group counselling skills; and
- family dynamics and treatment techniques.

In addition, building of clients' self-esteem and self-confidence was a identified as a strong need.

Powell and Thompson (1985) surveyed one hundred and ten military alcohol and drug abuse counsellors and their sixteen civilian clinical supervisors to determine similarities and differences in their perceptions of the training needs of the counsellors. Counsellor respondents were typically non-degreed, with less than 3 years experience. Their supervisors were typically licensed psychologists (the majority PhD's) with an average of 14 years experience. Both groups agreed that counsellors needed help with assessment skills, understanding family issues, and group skills. Supervisors differed from counsellors in also seeing a strong need for improvement in affective qualities, basic helping skills, and individual counselling skills.

Blane's (1985) survey of six hundred and twenty-six alcohol professionals in western Pennsylvania (70% return rate) assessed respondents' degree of interest in each of eleven possible topics. Of these respondents, a majority had received graduate training. Four topics were preferred:

- individual counselling;
- behavioural assessment and treatment;
- group counselling; and
- family evaluation, diagnosis and treatment.

Favoured formats for training were one-day workshops in university/college settings or urban convention centres. There was little interest in receiving undergraduate credits for training, but graduate credits and CEU's were of interest to almost half the respondents. Even more interest was expressed in training that would enable respondents to meet legal certification requirements.

Conclusions from Previous Studies

Although it is difficult to draw generalizations from these sources of data which vary from the informal to the methodologically sophisticated and which span a period of fifteen years, a few themes emerge.

Counselling skills are always an area of need. However, it appears that basic skills are not a priority need, except perhaps for those who are just beginning their work as drug and alcohol counsellors. Advanced skills needed to deal with groups, families, and multiple problem addicts are in demand. ***Assessment and referral*** skills are always important but now counsellors need up-to-date information on how to recognize the effects of new drugs and interactions between drugs. Skills in the area of ***prevention/public education***, including strategies like community mobilization and teaching/presentation skills, are high on the priority list. Skills in treating the abuser remain important but ***treatment*** of those affected by the abuser are also important.

Practitioners seek to keep up-to-date on new knowledge. Information about ***new drugs*** and their effects on users is always important. Currently, there is a need to understand the many ***special populations*** who seek help and their particular special needs, whether these be due to age, gender, ethnic background, or mental health. The special needs of First Nations persons and spiritual approaches to treatment appear to be a necessary part of the knowledge base. There is also a need to keep current with ***community resources.***

The need to constantly keep abreast of ***legal and ethical issues***, and to re-examine one's own attitudes towards abusers was also identified. Ongoing attention to the counsellor's ***self-care*** is critical as well.

Regarding the method of delivery of training, there is substantial agreement that ***distance education/correspondence/home study*** is needed to enhance practitioner's access to learning opportunities. ***Short courses and workshops*** continue to be an identified favourite mode of delivery. There is also a desire for some form of ***supervised skills practice*** (either coaching with feedback or clinical supervision).

Tables 1 and 2 summarize the findings of the previous needs analyses consulted for the purposes of this study. Because these previous analyses were conducted by many different agencies over a fifteen-year span, with no consistency in format or rigour, these summaries can only be rough at best. However, they serve as a useful reminder that field personnel have been surveyed regarding their preferred specific content and skill topics for training many times in the past, and that relatively consistent themes have been expressed.

Table 1: Content areas for training identified by previous needs assessments

Content Area	UVic 1990	Douglas 1990	VCC 1990	JI 1993	Pac.Inst. 90,92,93	Powell 1990	Armstrong 1978	Blane 1985	Lightfoot 1988
Chemical dependency theories	√	√		√					
• Adult development	√								
• Psychological and social correlates of addiction		√							
Community resources			√				√		√
Ethical and legal standards	√			√					
Mental health disorders and relevant medications				√					
Personal attitudes toward abusers							√		
Pharmacology	√	√	√	√					
• Symptoms/ behavioural effects of drugs			√		√		√		√
Prevention models	√	√	√						
Research findings	√								
Self care				√					
Special needs groups	√		√	√	√				
• Multicultural, including First Nations			√	√	√				
• Sexual abuse					√				
• HIV and AIDS				√					
• FAS/FAE					√				
Treatment models/strategies	√				√				
• Family and group dynamics	√		√	√		√			
• Health and wellness models	√								
• Constructive confrontation		√							
• Alternative models	√				√				
• Spiritual issues	√				√				
• Treatment of others affected by the abuse		√				√			
• Motivating abusers to seek treatment		√							
• Transference/countertransference issues				√					

Table 2: Skill areas for training identified by previous needs assessments

Skill Area	UVic 1989	Douglas 1989	VCC 1989	JI 1993	Pac.Inst. 90,92,93	Powell 1980	Armstrong 1978	Blane 1985	Lightfoot 1988
Administrative skills				√					
• Working with Boards				√					
• Financial management				√					
• Personnel management				√					
Assessment skills	√	√	√			√	√	√	√
Communication skills	√					√			
Counselling skills	√	√	√	√		√	√	√	√
• Family and group counselling		√		√		√	√	√	
• Working with street users		√			√				
• Working with multiple-problem addicts/dual diagnosis		√		√					
• Working with prescription drug users		√			√				
• Working with adolescents		√	√	√					
• Working with spouses/children of abusers (codependents)		√	√	√					
• Working with angry/abusive clients				√					
• Working with clients with trauma and post traumatic stress				√					
• Working with clients with HIV and AIDS				√					
• Vocational planning and placement								√	
Crisis intervention skills				√					
Presentation skills				√					
Prevention/public education	√	√		√	√				√
• Marketing/promotion	√								√
• Community mobilization	√								√
Referral		√	√		√				
Relapse prevention		√			√				

Methodology for Current Needs Assessment

Key Questions

At the first meeting of the project's Training Advisory Committee, committee members generated the key questions that were used to guide the needs assessment's strategic design.

The following questions emerged as most crucial (not in order of priority):

1. What is the basic minimum requirement to work in each setting?
2. What is the current level of qualifications of workers in the system of care?
3. What are the gaps between current level and desired level, as per role delineation study? (see below)
4. What are the topic areas of training needed, including areas of specialization?
5. What is the favoured mode of delivery?
6. How can we validate previous experience?
7. What are the incentives in the system for people to upgrade skills and knowledge?

Question 6 was judged to be outside the scope of this needs assessment. The remaining questions were used as guides in designing the needs assessment strategy. (Although question 6 could not be answered as part of this study, the issue was kept in mind as data-gathering proceeded.)

Data Gathering Methods

The project team developed the needs assessment strategy, which the committee endorsed. A 1991 Columbia Assessment Services, Inc. *Role Delineation Study for Alcohol and Other Drug Abuse Counsellors* was accepted as a starting point for the needs analysis. (As preparation for creating national certification examinations, this American national study defined the tasks performed by drug and alcohol counsellors.) The study's job analysis consisted of a DACUM-style brainstorming approach, followed by a national mail survey for validation. The resulting profile consists of five performance domains with individual tasks identified for each. The five domains are: assessment (11 tasks); counselling (15 tasks); case management (15 tasks); education (4 tasks); and professional responsibility (10 tasks). Each task is further broken down into needed "knowledges" and "skills".

The advisory committee reviewed the role delineation study to determine if any of the task descriptions should be added, deleted, or modified to adapt the framework to the British Columbia situation. The revised role delineation framework was then used as the basis for a questionnaire, which consisted of three sections.

Part 1 comprised demographic questions such as type of work, primary setting of work (e.g., detox, outpatient), special populations worked with, educational level, credentials, and years of experience.

Part 2 listed the tasks from the validated role delineation study and asked respondents to respond to each task in four different ways:

- Indicate whether or not the task is a requirement for their particular job. If it is not a part of their job, they could choose not applicable (n/a). They could then choose not to respond further to that particular task.
- Rate their current level of ability on the task, 1 being low and 5 being high.
- Indicate their desired level of ability on the task, 1 being low and 5 being high.

- In the last column, indicate whether they feel they could improve most in this task by on the job experience, or formal training; they could also choose no need to improve.
- In addition, if a task which is an important part of their job is not included, they could add and rate it in the space provided.

Part 3 asked a number of questions about motivation for taking training and concluded with an open-ended question inviting general input.

The questionnaire (see Appendix A) was mailed to a sample of British Columbia drug and alcohol workers. A stratified random sample was drawn from employee lists provided by Juanita Arthur, then Acting Manager of ADP Region 5 and Chair of the Training Advisory Committee. Care was taken to ensure that the sample was representative of all regions of the province.

A focus group was held to gain supervisors' perspectives on Key Question 1. Since most of the members of the Training Advisory Committee were supervisors or could take a supervisor's point of view, they were invited to take part in the focus group which was held during the committee's second meeting, on October 28, 1993. External facilitators Adrienne Burk and Andrea Kastner summarized the proceedings and results (see Appendix D).

Data from the questionnaire was analyzed and synthesized with data from the focus group.

The ADP Population and the Sample for the Questionnaire

Employee lists were provided by ADP for both direct service and funded agencies. Job titles were used to categorize employees for the purpose of the study. Where the appropriate category was in doubt, ADP recommended the final categorization. It was not always possible to differentiate between administrators and supervisors, so these categories were combined for sampling purposes only. The numbers of workers in each category in each region are shown in Table 3 below.

Table 3: Distribution of ADP direct service and funded agency workers by region

Category	Region 1	Region 2	Region 3	Region 4	Region 5	Total all regions	% of the population
Admin/Supervisors	54	30	25	18	48	175	14.71
Health Care Workers	86	15	20	6	26	153	12.86
Counsellors	148	101	84	63	80	476	40.00
Prevention Workers	5	7	5	10	12	39	3.28
Office Support/ Managers	58	46	47	33	44	228	19.16
Nurses	35	20	11	5	9	80	6.72
Physicians	0	0	1	0	10	11	0.92
Other	10	9	3	0	6	28	2.35
TOTALS	396	228	196	135	235	1190	100

From this population a stratified random sample was chosen. Care was taken to cover all regions adequately. "Physicians" and "others" were omitted, as their numbers were small. The percentage sampled in each category differed according to the size of the category. For example, all prevention workers were sampled because the total number is so small. Larger groups could be sampled at lower rates while still maintaining confidence in the representativeness of the sample.

Questionnaires were sent directly to each sampled individual, along with an envelope addressed to the project team at the University College of the Fraser Valley, ensuring confidentiality. A total of 448 questionnaires were distributed. Twenty-three were returned to the UCFV as undeliverable. The total responses were 149, for an overall (delivered) response rate of 35.1%. The percentages of each category sampled and the response rates from delivered questionnaires are shown in Table 4.

The response rates for all categories (using the categories derived from their job descriptions) fall into acceptable ranges, with the exception of "nurses" and "health care workers". The employee lists contained many names of nurses and health care workers who worked part-time. It is possible that their identification with the system of care might not have been sufficient to motivate them to respond. Therefore, throughout the report, the reader is advised to interpret results for health care workers with caution. The category of "nurses" presented further problems as explained below.

Table 4: Sampling rates of each identified category and response rates by category

Category	Total all regions	Percent of population	Number sampled	Percent sampled	Number responded	Response rate (delivered)
Admin/Supervisors	175	14.71%	80	45.7%	31	39.7%
Health Care Workers	153	12.86%	70	45.7%	18	27.3%
Counsellors	476	40.00%	116	24.4%	47	44.3%
Prevention Workers	39	3.28%	39	100%	15	38.5%
Office Support/ Managers	228	19.16%	86	37.7%	26	32.9%
Nurses	80	6.72%	57	71.3%	12	21.4%

Item number #1 on the questionnaire asked the respondent to classify him/herself. Unfortunately, the response category "nurse" was not provided in this question. Analysis of the data revealed that nurses, as identified by their response to question #5 concerning professional designation, were distributed across all the available categories with the exception of "office support/office manager". Therefore, we shall be unable to discuss the needs of nurses as a separate group. Given the many roles they play in the system of care, that may be the most appropriate route.

In addition, only twelve of the eighteen respondents we categorized as health care workers categorized themselves that way. In reality, the response rate in this category was much lower. Therefore, the results for the category "health care worker" throughout this report must be treated with great caution.

In the analysis and discussion of the results which follows and throughout the remainder of this report, the respondents' self categorization is used.

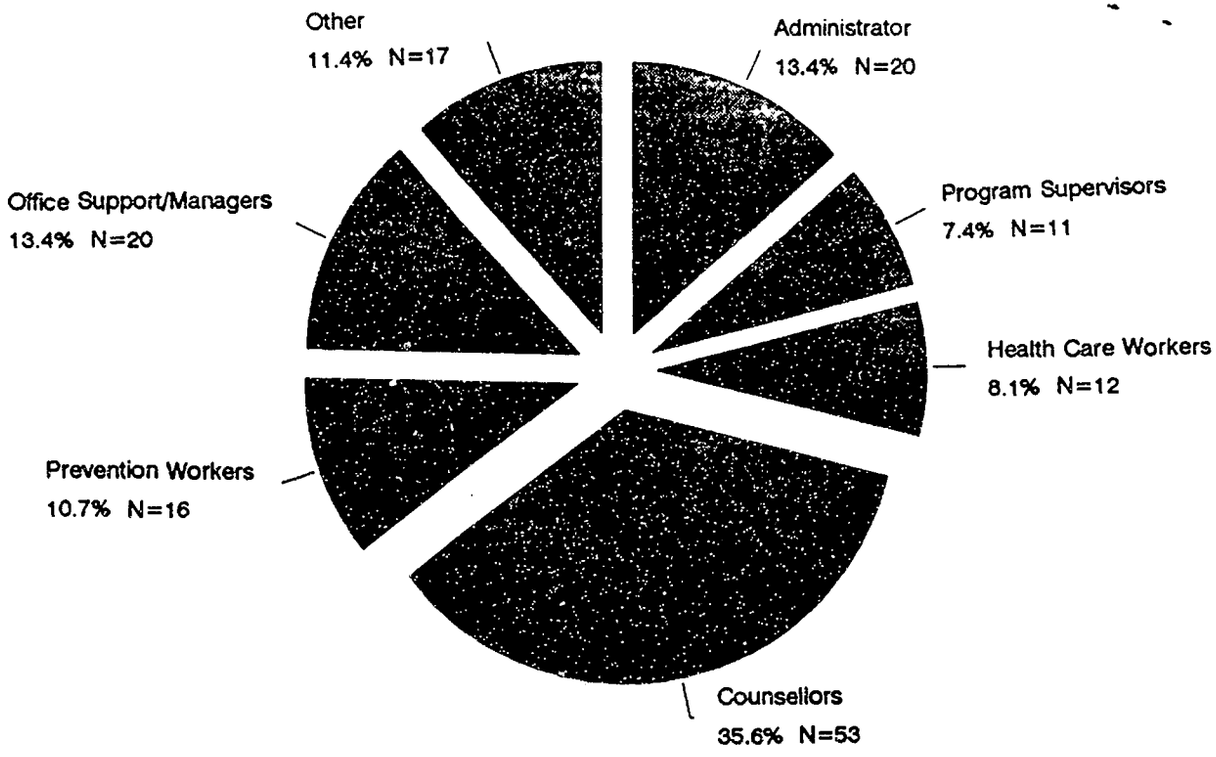
Questionnaire Results: Part 1 - Demographics

The first part of the questionnaire contained demographic and other descriptive questions. These characteristics of the respondent group are presented in question and answer format. The percentages across each row may not always sum to 100% due to rounding.

How do the respondents categorize themselves?

From a sample of 448 ADP workers, 149 responded (see Figure 1). Over a third of respondents categorized themselves as counsellors, with the next largest groups being administrators and office workers (both at 13.4%). Since the needs of these sub-groups are assumed to be quite different, results will presented primarily by category, only occasionally summarized across job categories.

Figure 1: Respondents' self-categorization by job.



Where do the respondents work?

As shown in Table 5 below, administrators are spread across the system. Our sample includes a large number of administrators in the "other" category, who may have been working in central or regional ADP offices. The program supervisors in our sample cluster in two work settings, outpatient services and detox centres. Health care workers are found only in residential treatment and detox facilities. Counsellors are spread across the system, but 66% of our sample work in outpatient services. Prevention workers are found primarily in the

schools. Fifty percent of the office workers in our sample are found in outpatient services. Collapsing across job categories, 41.8 % of the overall sample were from outpatient/non-residential services.

Table 5: Primary work setting of each category of respondent

Category	Residential Treatment	Supportive Recovery	Out-patient	Detox	School	Other
Administrators	15%	20%	10%	10%		45%
Program Supervisors			82%	18%		
Health Care Workers	17%			83%		
Counsellors	27%	6%	66%	8%	2%	2%
Prevention Workers			19%		75%	6%
Office Workers	10%	10%	50%		5%	25%
Other	35%	12%	24%	24%		6%
Overall Sample	**15%**	**7%**	**42%**	**15%**	**9%**	**11%**

Are they generalists or specialists?

As shown in Table 6, program supervisors and office workers consider themselves to be generalists; respondents in other job categories split roughly two-to-one, generalist to specialist.

Table 6: Respondents' self categorization as "generalist" or "specialist"

Category	"Generalists"	"Specialists"
Administrators	61%	39%
Program Supervisors	100%	
Health Care Workers	67%	33%
Counsellors	64%	34%
Prevention Workers	60%	40%
Office Workers	94%	6%
Other	65%	35%

Although only 41 respondents (27.5% of the total sample) labelled themselves as specialists in response to the first part of this question, 51 respondents (34.2%) responded to the second part of the question by specifying the special groups they worked with. Amongst those who responded to the second part of the question, the most frequently mentioned special groups were adolescents (23.5%), and women (19.6 %). These "specialists" were spread across job categories. Although 41.2% of the "specialists" indicated they were counsellors, only 34% of the counsellors indicated they were specialists.

What are their educational qualifications?

As shown in Table 7, over half the administrators and supervisors are university educated and 35% and 36% respectively have post-graduate degrees. All of the administrators have some post-secondary education. Health care workers tend to be high school graduates or holders of college certificates (1 year of study) or diplomas (2 years of study). The majority of counsellors (61%) are university educated, and 23% have post-graduate degrees. An additional 23% have college certificates or diplomas. Prevention workers tend to have Bachelor level degrees or higher. Office workers tend to be college graduates or have some university or college courses.

Table 7: Respondents' highest level of education

Category	Less than high school	High school	Some college or university	College certificate or diploma	Bachelors degree	Some post-graduate	Post-graduate degree
Administrators			10%	35%	15%	5%	35%
Program Supervisors			9%	27%	18%	9%	36%
Health Care Workers		42%		33%	17%	8%	
Counsellors	2%	6%	9%	23%	34%	4%	23%
Prevention Workers		6%	13%	19%	44%	6%	13%
Office Workers		25%	35%	40%			
Other	6%	10%	24%	12%	12%	12%	6%
Overall Sample	**1%**	**11%**	**14%**	**28%**	**23%**	**5%**	**17%**

What professional designations do they possess?

Professional credentials were varied and sparse. Only 62 of 149 respondents answered this question. The numbers in each job category were too small to allow for separate interpretation. Collapsing across job categories, and bearing in mind that only sixty-two people answered the question, the only discernible trends were:

- 13 respondents were RNs, spread across all job categories except office worker.
- 13 respondents were RPNs, and were either counsellors or administrators.
- 8 respondents were RSWs, primarily counsellors and prevention workers.

Possible interpretations of these results might be that professional designations are not always necessary to work in this field, or that those with professional designations were non-respondents.

How long have they been working in the drug and alcohol field?

Table 8 summarizes respondents' experience in the drug and alcohol field. Unfortunately, an editing change to the questionnaire which would have defined the second time period as "1 - 2 years" was inadvertently not implemented in the final draft of the questionnaire. Nonetheless, we believe that the data is sufficient to demonstrate a trend.

Predictably, administrators and supervisors generally have 6 or more years of experience while significant numbers of health care workers (42%) and prevention workers (62%) are fairly new to the field, having less than 3 years experience. The significant bulge at the 2-3 year level in all categories except administrators and supervisors may be attributable to the creation of more jobs in the system by the TRY initiative.

Table 8: Length of time working in the alcohol and drug field

Category	Less than 1 year	2-3 years	3-5 years	6-9 years	10 years or more
Administrators		15%	10%	15%	60%
Program Supervisors		9%	18%	36%	36%
Health Care Workers		42%	17%	17%	25%
Counsellors	11%	32%	21%	21%	15%
Prevention Workers	6%	56%	19%	19%	
Office Workers	5%	30%	35%	20%	10%
Other	12%	24%	12%	29%	24%
Overall Sample	**7%**	**30%**	**20%**	**22%**	**22%**

What kinds of agencies are they working for?

As shown in Table 9, our respondents were primarily from the funded agency sector (66% overall) except for those in the administrator category, which likely reflects the presence of administrators in central and regional offices.

Table 9: Type of agency for which respondents worked

Category	Direct Service	Funded Agency	Funded by NNADAP	Other
Administrators	42%	42%		16%
Program Supervisors	27%	55%		9%
Health Care Workers	36%	64%		
Counsellors	15%	79%	2%	4%
Prevention Workers		93%		7%
Office Workers	21%	53%	11%	16%
Other	21%	59%		18%
Overall Sample	**22%**	**66%**	**2%**	**9%**

How are they distributed around the province?

As can be seen in Table 10, the distribution of the sample by ADP Regions is roughly proportionate to that of the ADP population (see Table 3).

Table 10: Respondents' distribution by Region

Category	Region 1	Region 2	Region 3	Region 4	Region 5
Administrators	42%	16%	21%	11%	11%
Program Supervisors	18%	27%		27%	27%
Health Care Workers	58%	8%	17%		17%
Counsellors	26%	19%	26%	17%	10%
Prevention Workers	6%	13%	25%	25%	31%
Office Workers	5%		30%	25%	40%
Other	25%	31%	13%	19%	13%
Overall Sample	**25%**	**16%**	**22%**	**18%**	**19%**
% In Overall Population	**33%**	**19%**	**16%**	**12%**	**19%**

How do they spend their time?

The average percentage of time respondents reported spending in various activities is presented in Table 11. These percentages were calculated by averaging for each reported activity across all the respondents in a given job category. Responses to this question varied widely and not all respondents filled in percentages for all categories. Therefore, the percentages will not always add to 100, and interpretation should be limited to identifying general trends only.

Not surprisingly, administrators reported spending on average 78% of their time in management and agency liaison. Supervisors reported spending 56% of their time on these two activities, and a further 20% on prevention work and 19% in counselling. Health care workers report that they are primarily occupied in counselling, clerical work, and assessment and referral. Counsellors reported spending 51% of their time in counselling activities and prevention workers reported spending 51% of their time on prevention/public education.

Table 11: Reported average percentage of respondents' time spent in different activities.

Activity	Admin	Program Supervisors	Health Care Workers	Counsellors	Prevention Workers	Office Workers	Other
Assessment and referral	4%	6%	22%	14%	18%	1%	10%
Counselling	8%	19%	45%	51%	16%	0%	32%
Prevention/ public education	6%	20%	3%	12%	51%	3%	11%
Management	64%	46%	1%	6%	1%	10%	9%
Clerical/report-writing	9%	10%	29%	11%	6%	58%	15%
Agency liaison work	14%	10%	2%	6%	11%	3%	5%
Other	5%	5%	6%	10%	1%	8%	30%

Questionnaire Results: Part 2 - Tasks and Needs

In Part 2, the respondents were asked to review the tasks from the role delineation study and to respond to each one by answering four questions:

Is this a requirement of your work?
What is your *current* level of ability? (scale: 1=low to 5=high)
What is your *desired* level of ability (scale: 1=low to 5=high)
What is the best way to improve on this task?

Results are presented in four sections: tasks required for work; needs by job category; common needs; and respondents' identified best ways to improve on these tasks.

What tasks are required for each type of worker?

The tasks which 50% or more of the respondents in each job category agreed were required for their job are described below for each job category. Included as well is a summary description of any tasks for which they rated themselves *on average* 3.3 or lower on the 5 point scale (1=low to 5=high) entitled "current level of ability". The task descriptors used in this section and throughout the remainder of the report are summaries developed by the project team. Full task descriptors and detailed results are found in Appendix B.

Administrators

Administrators reported performing few tasks in the Assessment area; they are primarily occupied with conducting initial interviews, getting signed releases, and treatment planning. They rate their current level of ability highly (3.6 and 4.2 on the 5 point scale) on these tasks.

Administrators say they perform eleven of the fifteen Counselling tasks, focusing primarily on initiating and maintaining the individual counselling process, group therapy, relapse prevention, crisis intervention, client education, acknowledging cultural differences, and evaluating the success of counselling approaches. They rate their current performance highly on most of these tasks, the lowest being "assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition" (score=3.3), "provide group therapy to promote growth" (score=3.3), and "through case reviews, evaluate and assess counselling effectiveness" (score=3.2). It is interesting to note that "provide family therapy to promote individual and system growth" is not seen as a requirement of work by administrators or by any other job category group.

This group reports performing nine of the fourteen Case Management tasks, with the emphasis on the referral process, documentation, team consultation, client orientation, and maintaining community networks. They score themselves highly on the performance of all these tasks with the lowest self-ratings being for those activities involving team consultation. Once again it is interesting to note that neither administrators nor any other category see it as part of their job to "assist other treatment team members by providing alternative input on their cases".

Administrators see client education as their main responsibility in the Education domain, and they rate their performance of this task highly.

All of the Professional Responsibility tasks are seen by administrators as requirements of their jobs. They give themselves the lowest ratings on their current performance in this domain for "conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and limitations" (score=3.1), "obtain appropriate continuing professional education" (score=3.2), "assess and participate in regular supervision and consultation sessions" (score=2.9), and "establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources" (score=3.3).

Program Supervisors

Program supervisors report performing seven of the eleven listed Assessment tasks. In addition to being occupied with conducting initial interviews, getting signed releases, and treatment planning, they also report spending time documenting signs and symptoms, assessing the match between client needs and program services, recognizing situations which require assistance from outside sources, and documenting ongoing needs to adjust the treatment plan. They rate their current performance highly on all these tasks, with the lowest being "observe and document abuse/dependence for diagnosis and treatment plan" (score=3.3) and "match client with program" (score=3.3). Once again, tasks not considered to be part of the job are interesting to note, including "gather and validate client information from other sources", a task not seen to be part of the job by respondents in any of the job categories.

This group reports performing thirteen of the fifteen Counselling tasks, omitting only those two which are omitted by all job categories, namely "provide family therapy to promote individual and system growth" and "identify group purpose, rules, goals and membership criteria to facilitate interaction and communication". Like administrators, they report focusing on initiating and maintaining the individual counselling process, group therapy, relapse prevention, crisis intervention, client education, acknowledging cultural differences and evaluating the success of counselling approaches. In addition, they report spending time on follow-up (Counselling tasks 10 and 11). They rate their current performance highly on most of these tasks, the lowest being "assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition" (score=3.1), "provide group therapy to promote growth" (score=3.3), "assist clients and significant others establish and maintain new behaviours in order to minimize relapse" (score=3.1), "provide appropriate care and follow-up" (score=3.1), "assess ongoing issues and progress through review of goals and accomplishments" (score=3.3), and "provide information to client and significant others through written materials and other educational forums" (score=3.1).

Program supervisors report performing eleven of the fourteen tasks in the Case Management domain. Like administrators, they focus on the referral process, documentation, team consultation, client orientation, and maintaining community networks. However, they also emphasize referral to self-help groups and "obtain(ing) evaluation through regular consultation with supervisors and peers in order to assess case management techniques". They rate their current performance on all of these tasks highly, with the lowest being those involved with team consultation (3.1 and 2.9) and assessing case management techniques (score=3.3). Once again it is interesting to note that program supervisors, like those in other job categories, do not see as part of their job the task "assist other treatment team members by providing alternative input on their cases".

Program supervisors say they perform all four of the Education tasks, but give themselves relatively low current performance ratings on three of them: client education (score=2.8); family education (score=3.1); and community education (score=3.2).

All of the Professional Responsibility tasks are seen by this group as part of their jobs, with the lowest current performance ratings being on "interpret and apply information from current counselling and alcohol and other drug abuse literature" (score 3.3), "develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship" (score=3.3), "conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and weaknesses" (score=3.0), "obtain appropriate continuing professional education" (score=3.0), "assess and participate in regular supervision and consultation sessions" (score=2.7), and "establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources" (score=3.2).

Health Care Workers[1]

Health care workers report performing only three tasks in the Assessment domain. These include conducting initial interviews, getting signed releases, and treatment planning. They give themselves high ratings for their current performance on these tasks.

This group reports performing eight of the fifteen Counselling tasks, focusing on initiating and maintaining the individual counselling process, crisis intervention, acknowledging cultural differences, and evaluating the success of counselling approaches. They rate their current performance highly on most of these tasks, the lowest being "assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition" (score=3.3), and "through case reviews, evaluate and assess counselling effectiveness" (score=3.1).

Health care workers report performing only five of the fourteen Case Management tasks. They focus on the referral process, documentation, and team consultation. They give their current performance relatively high ratings on each of these tasks, with the lowest ratings being on those tasks involving team consultation (3.3 and 3.1).

Health care workers see themselves as performing none of the Education tasks.

They report performing all of the Professional Responsibility tasks, with the exception of "demonstrate ethical behaviours by adhering to established professional code of ethics". Lowest self-ratings of current performance occur for "conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and limitations" (score=3.1), "obtain appropriate continuing professional education" (score=3.1), and "assess and participate in reguiar supervision and consultation sessions" (score=3.2).

Counsellors

Counsellors report performing seven of the eleven Assessment tasks, focusing primarily on conducting initial interviews, documenting signs and symptoms, assessing the match between clients needs and program services, getting signed releases, recognizing situations which require assistance from outside sources, and treatment planning. They are the first group to

[1]Results of this group must be interpreted with great caution due to the low response rate discussed previously.

see as part of their job the task "explain assessment process to client". They give themselves high ratings for their current performance of all these tasks, with the lowest ratings being for "match client with program" (score=3.3). Once again, tasks not considered to be part of the job are interesting to note, including "gather and validate client information from other sources", a task not seen to be part of the job by respondents in any of the job categories.

This group reports performing eleven of the fifteen Counselling tasks, omitting not only those two which are omitted by all job categories ("provide family therapy to promote individual and system growth" and "identify group purpose, rules, goals and membership criteria to facilitate interaction and communication") but also omitting the two tasks related to follow-up, "provide appropriate care and follow-up" and "assess ongoing issues and progress through review of goals and accomplishments". Like administrators and program supervisors, they focus on initiating and maintaining the individual counselling process, group therapy, relapse prevention, crisis intervention, client education, acknowledging cultural differences and evaluating the success of counselling approaches. They rate their current performance highly on most of these tasks, the lowest being "provide group therapy to promote growth" (score=3.3) and "assist clients and significant others establish and maintain new behaviours in order to minimize relapse" (score=3.3).

Counsellors say they perform twelve of the fourteen Case Management tasks. Like program supervisors, they focus on the referral process, documentation, team consultation, client orientation, referral to self-help groups, maintaining community networks, and "obtain(ing) evaluation through regular consultation with supervisors and peers in order to assess case management techniques". They consider it part of their job to "provide information in order to ensure adequate funding for services provided". Counsellors rate their current performance on all these tasks highly, with the lowest ratings being for "present cases to other treatment team members" (score=3.1) and "obtain(ing) evaluation through regular consultation with supervisors and peers in order to assess case management techniques" (score=3.3). Like program supervisors - and those in all other job categories - counsellors do not see as part of their job the task "assist other treatment team members by providing alternative input on their cases".

Counsellors report performing three of the four Education tasks, omitting "provide relevant education to family members and significant others to support the recovery process", but give themselves low current performance ratings on two of them, client education (score=2.8) and community education (score=2.9).

All of the Professional Responsibility tasks were seen by counsellors as part of the job. Their lowest current performance ratings were for the tasks "interpret and apply information from current counselling and alcohol and other drug abuse literature" (score 3.3), "develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship" (score=3.3), "conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and limitations" (score=3.0), "obtain appropriate continuing professional education" (score=3.0), "assess and participate in regular supervision and consultation sessions" (score=2.8), and "establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources" (score=3.1). They give themselves the lowest current performance rating of any category for self-care, to "develop and use strategies to maintain personal, physical and mental health" (score=3.3).

Prevention Workers

Prevention workers say they perform nine of the eleven Assessment tasks listed. Like program supervisors, they are occupied with conducting initial interviews, documenting signs and symptoms, assessing the match between clients needs and program services, getting signed releases, recognizing situations which require assistance from outside sources, and treatment planning. Like counsellors, they explain the assessment process to the client. They are the first group to see "develop a written diagnostic summary as the basis for an integrated approach to diagnosis and treatment planning" as part of their job. They are the only group who include use of standardized assessment instruments as part of their job. They rate their current performance on each of these tasks highly, with no scores below 3.4 on the 5-point scale.

This group reports performing twelve of the fifteen Counselling tasks, omitting those two which are omitted by all job categories ("provide family therapy to promote individual and system growth" and "identify group purpose, rules, goals and membership criteria to facilitate interaction and communication"), but also omitting "assist clients and significant others establish and maintain new behaviours in order to minimize relapse". They focus on initiating and maintaining the individual counselling process, group therapy, crisis intervention, follow-up tasks, client education, acknowledging cultural differences and evaluating the success of counselling approaches. They give their current performance high ratings on most of these tasks, the lowest self-ratings being for "assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition" (score=3.3) and "provide appropriate care and follow-up" (score=3.2).

Prevention workers say they perform ten of the fourteen Case Management tasks. Like program supervisors, they focus on the referral process, documentation, team consultation, client orientation, referral to self-help groups, and maintaining community networks. They do not include among the tasks required by their job the task "obtain evaluation through regular consultation with supervisors and peers in order to assess case management techniques". They give themselves relatively high current performance ratings on this set of tasks, with the lowest ratings being for the two tasks involving team consultation (Task 5=3.0 and Task 6 =3.1). Like those respondents in other job categories, prevention workers do not see as part of their job the task "assist other treatment team members by providing alternative input."

Prevention workers report performing all four of the tasks in the Education domain, but give themselves low current performance ratings on both client education (score=2.8) and family education (score=3.2).

All of the Professional Responsibility tasks are seen as part of a prevention worker's job. This group gives their lowest current performance self-ratings to the tasks "conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and weaknesses" (score=3.0), "obtain appropriate continuing professional education" (score=3.3), and "assess and participate in regular supervision and consultation sessions" (score=2.7).

Office Workers

Office support workers and office managers indicate that they perform seven of the eleven Assessment tasks listed. They report being occupied with conducting initial interviews, documenting signs and symptoms, assessing the match between clients needs and program

services, getting signed releases, recognizing situations which require assistance from outside sources, and treatment planning. Like prevention workers, they see developing a written diagnostic summary as part of their job. They give their current performance on these tasks high ratings, with the only low score being 3.3 on assessing the match between client need and program services.

This group reports performing eleven of the fifteen Counselling tasks, omitting those two which are omitted by all job categories, ("provide family therapy to promote individual and system growth" and "identify group purpose, rules, goals and membership criteria to facilitate interaction and communication") and also omitting the two tasks having to do with follow-up. They report focusing on initiating and maintaining the individual counselling process, group therapy, relapse prevention, crisis intervention, client education, acknowledging cultural differences and evaluating the success of counselling approaches. They rate their current performance highly on most of these tasks, the lowest being "assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition" (score=3.3), "provide group therapy to promote growth" (score=3.2), and "through case reviews, evaluate and assess counselling effectiveness" (score=3.2).

Office workers report performing ten of the fourteen Case Management tasks. Like program supervisors, they focus on the referral process, documentation, team consultation, client orientation, and maintaining community networks. They are the only group to include within their job requirements the task "advocate for client's interests in targeted systems". They give themselves relatively high current performance ratings on all these tasks, with the lowest ratings being for "consult with supervisors and other service provides to assure comprehensive, quality care for the client" (score=3.3) and "present cases to other treatment team members" (score=3.1). Like those in other job categories, they do not see as part of their job the task "assist other treatment team members by providing alternative input".

Office workers give themselves a high self-rating on their current performance of the one Education task they consider part of their job, "provide relevant education to client to support the recovery process".

All of the Professional Responsibility tasks are seen by respondents in this job category as components of their work. Their lowest self-ratings on current performance are for "conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and limitations" (score=3.2), "obtain appropriate continuing professional education" (score=3.2), "assess and participate in regular supervision and consultation sessions" (score=2.9), and "establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources" (score=3.2).

Other

No results will be reported for this group as it is too heterogeneous in makeup to allow for accurate interpretation.

What are the training needs for each type of worker?

Respondents' priority training needs were identified by analysing the difference between a group's current performance level on a given task and their desired performance level on that task. In this section, identified training needs are those tasks which:

- are reported as performed by 50% or more of the respondents in a given job category;
- have a difference of 1.0 or more between that category's respondents' ratings of their current performance level and their desired performance level; and
- are identified as requiring improvement in performance level by 50% or more of respondents in the job category.

By using this definition, it is assured that "training needs" are rooted in the requirements of the job and the gap between current and desired level of skill.

Results are presented by job category in Tables 10 through 14. Only those tasks which 50% or more of the respondents in that job category agreed were a requirement of the job and for which the difference between desired and current level was 1.0 or greater are shown. (Difference measures of greater than 1.5 are identified in each table by boldface type and asterisks.) A condensed wording for each task has been provided to ease interpretation. For the full task descriptors, see Appendices A and C.

In each job category, a few tasks were identified which did not meet the 50% "reported as performed" criteria but did have high Difference measures. These may represent tasks on which people want to improve even though the task is not identified as a requirement of the job. One interpretation might be that improved performance on these tasks is seen by respondents as a path to increased job mobility or enhanced performance in their current work. For interest, these "job enhancement/mobility" tasks are listed at the end of each section, though they should not be seen as priority training needs.

Administrators

As shown in Table 12, the largest gap between current and desired performance for administrators were in the areas of Counselling, Case Management, and Professional Responsibility. Within the Counselling area, the needs focused on increased competence in individual, family and group therapy. Within Case Management, the highest priority needs related to keeping current on community resources for the purpose of referral and on conferring with other team members regarding treatment. Within Professional Responsibility, the key areas were self evaluation and supervisor consultation aimed at personal growth and development.

Table 12: Administrators' gaps between current and desired performance.

Task	Respondents who said this was a requirement of their job	Difference between current level and desired level of ability
Domain: Assessment		
9. Formulate mutually agreed upon treatment goals, objectives and methods.	75%	1.0
Domain: Counselling		
3. Assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition.	73.7%	**1.79***
4. Provide unique individual therapy to promote a quality recovery process.	85%	**1.72***
6. Provide group therapy to promote growth.	60%	**1.71***
8. Assist clients and significant others establish and maintain new behaviours in order to minimize relapse.	65%	1.5
12. Provide information to client and significant others through written materials and other educational forums.	75%	1.33
13. Acknowledge and respect cultural and life-style diversities.	85%	1.26
15. Through case reviews, evaluate and assess counselling effectiveness.	78.9%	1.46
Domain: Case Management		
1. Maintain community referral resource information through contact with other service providers.	85%	**1.58***
2. Match community resources with client needs.	75%	1.18
3. Verbally explain to client the necessity for referral.	85%	1.13
4. Maintain client records to prescribed standards.	85%	1.45
5. Consult with supervisors and other service providers to ensure comprehensive, quality care for the client.	85%	**1.63***
6. Present cases to other treatment team members.	77.8%	**1.75***
Domain: Education		
1. Provide relevant education to client to support the recovery process.	75%	1.24
Domain: Professional Responsibility		
3. Interpret and apply information from current counselling and alcohol and other drug abuse literature.	85%	1.24
4. Recognize the importance of individual differences by gaining knowledge about factors influencing client behaviour.	85%	1.06
5. Develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship.	85%	1.29
6. Conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and limitations.	78.9%	**1.76***
7. Obtain appropriate continuing professional education.	85%	**1.56***
8. Assess and participate in regular supervision and consultation sessions.	85%	**1.94***
9. Develop and use strategies to maintain personal, physical and mental health.	85%	1.22
10. Establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources.	85%	1.5

* Difference of greater than 1.5

Potential "job enhancement/mobility" training for administrators could address the following:

Assessment Tasks

2. Gather and validate client information from other sources.
3. Observe and document abuse/dependence for diagnosis and treatment plans.
4. Match client with program.
6. Recognize need for outside assessment expertise.

Counselling Tasks

7. Identify group purpose, rules, goals and membership criteria to facilitate interaction and communication.
10. Provide appropriate care and follow-up.
11. Assess ongoing issues and progress through review of goals and accomplishments.

Case Management Tasks

11. Advocate for client's interests in targeted systems.
14. Obtain evaluation through regular consultation with supervisors and peers in order to assess case management techniques.

Education Tasks

2. Provide relevant education to family members and significant others to support the recovery process.
3. Provide alcohol and drug education to the community in order to raise awareness and enhance community support.
4. Provide drug and alcohol education and information to colleagues and other professionals to enhance professional exchange of information and ensure continuum of care.

Program Supervisors

As shown in Table 13, the highest priority needs for program supervisors were in the areas of Counselling, Case Management, Education, and Professional Responsibility. Within the Counselling area, the gaps between current and desired performance related to increased competence in individual and family therapy. Within Case Management, the highest priority needs focused on presenting cases to other team members for consultation on suggested treatment. Within Education, the priority was on direct education of the client. Within Professional Responsibility, the key area was supervisor consultation aimed at personal growth and development.

For program supervisors, additional potential "job enhancement/mobility" training could address:

Assessment Tasks

7. Develop written diagnostic summary as basis for integrated approach to diagnosis and treatment planning.

Counselling Tasks

5. Provide family therapy to promote individual and system growth.
7. Identify group purpose, rules, goals and membership criteria to facilitate interaction and communication.

Case Management Tasks

7. Assist other treatment team members by providing alternative input on their cases.
11. Advocate for client's interest in targeted systems.

Table 13: Program supervisors' gaps between current and desired performance

Task	Respondents who said this was a requirement of their job	Difference between current level and desired level of ability
Domain: Assessment		
3. Observe and document abuse/dependence from other sources.	63.6%	1.1
4. Match client with program.	72.7%	1.1
Domain: Counselling		
3. Assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition.	90.0%	1.64*
4. Provide unique individual therapy to promote a quality recovery process.	81.8%	1.60*
6. Provide group therapy to promote growth.	81.8%	1.4
8. Assist clients and significant others establish and maintain new behaviours in order to minimize relapse.	81.8%	1.5
10. Provide appropriate care and follow-up.	54.5%	1.33
11. Assess ongoing issues and progress through review of goals and accomplishments.	54.5%	1.11
12. Provide information to client and significant others through written materials and other educational forums.	81.8%	1.44
13. Acknowledge and respect cultural and life-style diversities.	90.9%	1.44
Domain: Case Management		
1. Maintain community referral resource information through contact with other service providers.	90.9%	1.1
2. Match community resources with client needs.	72.7%	1.0
4. Maintain client records to prescribed standards.	90.9%	1.44
5. Consult with supervisors and other service providers to assure comprehensive, quality care for the client.	90.9%	1.4
6. Present cases to other treatment team members.	81.8%	1.6*
14. Obtain evaluation through regular consultation with supervisors and peers in order to assess case management techniques.	63.6%	1.3
Domain: Education		
1. Provide relevant education to client to support the recovery process.	72.7%	1.91*
2. Provide relevant education to family members and significant others to support the recovery process.	54.5%	1.33
3. Provide alcohol and drug education to the community in order to raise awareness and enhance community support.	54.5%	1.25
Domain: Professional Responsibility		
1. Demonstrate ethical behaviours by adhering to established professional code of ethics.	72.7%	1.0
3. Interpret and apply information from current counselling and alcohol and other drug abuse literature.	90.9%	1.2
4. Recognize the importance of individual differences by gaining knowledge about factors influencing client behaviour.	90.9%	1.0
5. Develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship.	90.9%	1.3

Task	Respondents who said this was a requirement of their job	Difference between current level and desired level of ability
6. Conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and limitations.	90.9%	1.45
7. Obtain appropriate continuing professional education.	90.0%	1.5
8. Assess and participate in regular supervision and consultation sessions.	90.9%	1.7*
9. Develop and use strategies to maintain personal, physical and mental health.	90.9%	1.1
10. Establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources.	90.9%	1.3
		* Difference of greater than 1.5

Health Care Workers

As shown in Table 14, the largest gaps between current and desired performance for health care workers were in the areas of Counselling, Case Management, and Professional Responsibility. Within the Counselling area, the needs focused on increased competence in individual and family therapy and evaluating the quality of the counselling approach chosen. Within the Case Management area, the highest priority needs focused on keeping current on community resources for the purpose of referral, and conferring with other team members regarding treatment. Within Professional Responsibility, the key areas related to self evaluation, appropriate continuing education, and supervisor consultation aimed at personal growth and development.

An interesting anomaly appeared for health care workers regarding Task 4 under Case Management, "Maintain client records to prescribed standards". Although 75% of the health care workers said they performed this task, and the average difference between desired and current performance levels was 1.05, 66.7% of the workers said there was no need for improvement. This might be interpreted to mean that while most them feel happy with their "paperwork skills", a small minority need help with this required part of their job.

For health care workers, the additional "job enhancement/job mobility" training might address:

Assessment Tasks

3. Observe and document abuse/dependence for diagnosis and treatment plan.
4. Match client with program.
6. Recognize need for outside assessment expertise.
7. Develop written diagnostic summary as basis for integrated approach to diagnosis and treatment planning.

Counselling Tasks

5. Provide family therapy to promote individual and system growth.
6. Provide group therapy to promote growth.
7. Identify group purpose, rules, goals and membership criteria to facilitate interaction and communication.
8. Assist clients and significant others establish and maintain new behaviours in order to minimize relapse.
10. Provide appropriate care and follow-up.

11. Assess ongoing issues and progress through review of goals and accomplishments.
12. Provide information to client and significant others through written materials and other educational forums.
15. Through case reviews, evaluate and assess counselling effectiveness.

Case Management Tasks

4. Maintain client records to prescribed standards.
8. Verbally explain to the client the need for consultation and obtain written consent when needed.
11. Advocate for client's interests in targeted systems.
13. Maintain a network of community resources in order to enhance client's treatment.
14. Obtain evaluation through regular consultation with supervisors and peers in order to assess case management techniques.

Table 14: Health Care Workers' gaps between current and desired performance

Task	Respondents who said this was a requirement of their job	Difference between current level and desired level of ability
Domain: Assessment		
9. Formulate mutually agreed upon treatment goals, objectives, and methods.	50.0%	1.4
Domain: Counselling		
3. Assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition.	72.7%	1.67*
4. Provide unique individual therapy to promote a quality recovery process.	75.0%	1.8*
13. Acknowledge and respect cultural and life-style diversities.	75.0%	1.18
15. Through case reviews, evaluate and assess counselling effectiveness.	66.7%	1.83*
Domain: Case Management		
1. Maintain community referral resource information through contact with other service providers.	75.0%	1.75*
3. Consult with supervisors and other service providers to assure comprehensive, quality care for the client.	75.0%	1.6*
5. Present cases to other treatment team members.	70.0%	1.8*
Domain: Professional Responsibility		
3. Interpret and apply information from current counselling and alcohol and other drug abuse literature.	75.0%	1.09
5. Develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship.	75.0%	1.2
6. Conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and limitations.	70.0%	1.82*
7. Obtain appropriate continuing professional education.	75.0%	1.56*
8. Assess and participate in regular supervision and consultation sessions.	75.0%	1.58*
10. Establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources.	75.0%	1.25

* Difference of greater than 1.5

Counsellors

As shown in Table 15, the largest gaps between current and desired performance for counsellors were in the areas of Counselling, Education, and Professional Responsibility. Within the Counselling area, the needs focused on increased competence in individual, family, and group therapy. Within the Education area, the highest priority needs related to direct client education and community education. Within the Professional Responsibility area, the key areas were self-evaluation and supervisor consultation aimed at personal growth and development.

For counsellors, the additional potential "job enhancement/job mobility" training could related to:

Counselling Tasks

5. Provide family therapy to promote individual and system growth.
7. Identify group purpose, rules, goals and membership criteria to facilitate interaction and communication.
10. Provide appropriate care and follow-up.
11. Assess ongoing issues and progress through review of goals and accomplishments.

Case Management Tasks

7. Assist other treatment team members by providing alternative input on their cases.
11. Advocate for client's interests in targeted systems.

Education Tasks

2. Provide relevant education to family members and significant others to support the recovery process.

Table 15: Counsellors' gaps between current and desired performance

Task	Respondents who said this was a requirement of their job	Difference between current level and desired level of ability
Domain: Assessment		
3. Observe and document abuse/dependence for diagnosis and treatment plan.	64.7%	1.0
4. Match client with program.	64.7%	1.15
Domain: Counselling		
3. Assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition.	80.0%	1.72*
4. Provide unique individual therapy to promote a quality recovery process.	94.3%	1.59*
6. Provide group therapy to promote growth.	60.4%	1.69*
8. Assist clients and significant others establish and maintain new behaviours in order to minimize relapse.	77.4%	1.45
12. Provide information to client and significant others through written materials and other educational forums.	79.2%	1.24
13. Acknowledge and respect cultural and life-style diversities.	94.3%	1.2
Domain: Case Management		
1. Maintain community referral resources information through contact with other service providers.	94.3%	1.13
2. Match community resources with client needs.	79.2%	1.05
4. Maintain client records to prescribed standards.	94.3%	1.38

Task	Respondents who said this was a requirement of their job	Difference between current level and desired level of ability
5. Consult with supervisors and other service providers to assure comprehensive, quality care for the client.	94.3%	1.14
6. Present cases to other treatment team members.	85.1%	1.43
14. Obtain evaluation through regular consultation with supervisors and peers in order to assess case management techniques.	55.3%	1.34
Domain: Education		
1. Provide relevant education to client to support the recovery process.	77.4%	1.86*
3. Provide alcohol and drug education to the community in order to raise awareness and enhance community support.	56.6%	1.6*
4. Provide drug and alcohol education and information to colleagues and other professionals to enhance professional exchange of information and ensure continuum of care.	56.6%	1.2
Domain: Professional Responsibility		
3. Interpret and apply information from current counselling and alcohol and other drug abuse literature.	92.5%	1.24
4. Recognize the importance of individual differences by gaining knowledge about factors influencing client behaviour.	94.3%	1.06
5. Develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship.	94.3%	1.2
6. Conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and weaknesses.	85.7%	1.56*
7. Obtain appropriate continuing professional education.	94.3%	1.48
8. Assess and participate in regular supervision and consultation sessions.	94.3%	1.8*
9. Develop and use strategies to maintain personal, physical and mental health.	94.3%	1.24
10. Establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources.	94.3%	1.31
		* Difference of greater than 1.5

Prevention Workers

As shown in Table 16, the largest gaps between current and desired performance for prevention workers were in the areas of Counselling, Case Management, Education, and Professional Responsibility. Within the Counselling area, the needs focused on increased competence in individual and family therapy. Within the Case Management area, the highest priority needs focused on conferring with other team members regarding treatment. Within the Education area, the highest priority needs related to direct client education and education of the family. Within the Professional Responsibility area, the key areas were self-evaluation and supervisor consultation aimed at personal growth and development.

The "paper work" anomaly appeared again for prevention workers. Regarding Task 4 under Case Management ("Maintain client records to prescribed standards"), while 68.8% of the prevention workers identified this task as required on the job and the average difference between desired and current levels was 1.5, over half (56.3%) of the workers said there was no need for improvement. Again, this might be interpreted to mean that while most prevention workers feel happy with their "paperwork skills", a small minority need help with this required part of their job.

Additional potential "job enhancement/job mobility" training could focus on:

Assessment Tasks

2. Gather and validate client information from other sources.

Counselling Tasks

5. Provide family therapy to promote individual and system growth.
7. Identify group purpose, rules, goals and membership criteria to facilitate interaction and communication.
8. Assist clients and significant others establish and maintain new behaviours in order to minimize relapse.

Case Management Tasks

7. Assist other treatment team members by providing alternative input on their cases.
11. Advocate for client's interests in targeted systems.
14. Obtain evaluation through regular consultation with supervisors and peers in order to assess case management techniques.

Table 16: Prevention workers' gaps between current and desired performance

Task	Respondents who said this was a requirement of their job	Difference between current level and desired level of ability
Domain: Assessment		
3. Observe and document abuse/dependence for diagnosis and treatment plan.	81.3%	1.0
4. Match client with program.	81.3%	1.17
7. Develop written diagnostic summary as basis for integrated approach to diagnosis and treatment planning.	56.3%	1.11
Domain: Counselling		
3. Assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition.	64.3%	1.75*
4. Provide unique individual therapy to promote a quality recovery process.	68.8%	1.75*
6. Provide group therapy to promote growth.	50.0%	1.5
10. Through case reviews, evaluate and assess counselling effectiveness.	60.0%	1.5
11. Assess ongoing issues and progress through review of goals and accomplishments.	60.0%	1.07
12. Provide information to client and significant others through written materials and other educational forums.	56.3%	1.0
13. Acknowledge and respect cultural and life-style diversities.	68.8%	1.0
15. Through case reviews, evaluate and assess counselling effectiveness.	56.3%	1.0

Task	Respondents who said this was a requirement of their job	Difference between current level and desired level of ability
Domain: Case Management		
1. Maintain community referral resources information through contact with other service providers.	68.8%	1.09
2. Match community resources with client needs.	62.5%	1.36
5. Consult with supervisors and other service providers to assure comprehensive, quality care for the client.	68.8%	1.72*
6. Present cases to other treatment team members.	53.3%	1.55*
Domain: Education		
1. Provide relevant education to client to support the recovery process.	62.5%	1.83*
2. Provide relevant education to family members and significant others to support the recovery process.	56.3%	1.5*
3. Provide alcohol and drug education to the community in order to raise awareness and enhance community support.	56.3%	1.27
Domain: Professional Responsibility		
3. Interpret and apply information from current counselling and alcohol and other drug abuse literature.	68.8%	1.0
4. Recognize the importance of individual differences by gaining knowledge about factors influencing client behaviour.	68.8%	1.3
5. Develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship.	68.8%	1.27
6. Conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and weaknesses.	56.3%	1.62*
7. Obtain appropriate continuing professional education.	68.8%	1.42
8. Assess and participate in regular supervision and consultation sessions.	68.8%	2.0*
9. Develop and use strategies to maintain personal, physical and mental health.	68.8%	1.27
10. Establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources.	68.8%	1.33
		* Difference of greater than 1.5

Office Workers

As shown in Table 17, the largest gaps between current and desired performance for office support workers and office managers were in the areas of Assessment, Counselling, Case Management, and Professional Responsibility. Within the Assessment area, office workers wanted help with determining client eligibility and matching client to treatment. Within the Counselling area, the needs focused on increased competence in individual and family therapy and assisting client and others with relapse prevention. Within the Case Management area, the highest priority need was presenting cases to other team members. Within the Professional Responsibility area, the key areas focused on self-evaluation, obtaining appropriate continuing education, and supervisor consultation aimed at personal growth and development.

For office workers, additional potential "job enhancement/job mobility" training could relate to:

Assessment Tasks

9. Formulate mutually agreed-upon treatment goals, objectives and methods.

Counselling Tasks

5. Provide family therapy to promote individual and system growth.
7. Identify group purpose, rules, goals and membership criteria to facilitate interaction and communication.
10. Provide appropriate care and follow-up.

Case Management Tasks

12. Provide information in order to ensure adequate funding for services provided.
14. Obtain evaluation through regular consultation with supervisors and peers in order to assess case management techniques.

Education Tasks

2. Provide relevant education to family members and significant others to support the recovery process.
3. Provide alcohol and drug education to the community in order to raise awareness and enhance community support.
4. Provide drug and alcohol education and information to colleagues and other professionals to enhance professional exchange of information and ensure continuum of care.

Table 17: Office workers' gaps between current and desired performance

Task	Respondents who said this was a requirement of their job	Difference between current level and desired level of ability
Domain: Assessment		
3. Observe and document abuse/dependence for diagnosis and treatment plan.	55.0%	1.29
4. Match client with program.	55.0%	1.53*
6. Recognize need for outside assessment expertise.	55.0%	1.12
9. Formulate mutually agreed upon treatment goals, objectives and methods.	75.0%	1.0
Domain: Counselling		
3. Assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition.	58.8%	1.73*
4. Provide unique individual therapy to promote a quality recovery process.	80.0%	1.8*
6. Provide appropriate care and follow-up.	63.2%	1.45
8. Assist clients and significant others establish and maintain new behaviours in order to minimize relapse.	65.0%	1.53*
12. Provide information to client and significant others through written materials and other educational forums.	75.0%	1.22
13. Acknowledge and respect cultural and life-style diversities.	80.0%	1.35
15. Through case reviews, evaluate and assess counselling effectiveness.	78.9%	1.2

Task	Respondents who said this was a requirement of their job	Difference between current level and desired level of ability
Domain: Case Management		
1. Maintain community referral resource information through contact with other service providers	80.0%	1.47
2. Match community resources with client needs.	75.0%	1.06
3. Verbally explain to client the necessity for referral.	80.0%	1.12
4. Maintain client records to prescribed standards.	78.9%	1.4
5. Consult with supervisors and other service providers to assure comprehensive, quality care for the client.	80.0%	1,47
6. Present cases to other treatment team members.	77.8%	1.69*
11. Advocate for client's interests in targeted systems.	53.3%	1.46
Domain: Education		
1. Provide relevant education to client to support the recovery process.	75.0%	1.42
Domain: Professional Responsibility		
3. Interpret and apply information from current counselling and alcohol and other drug abuse literature.	80.0%	1.44
4. Recognize the importance of individual differences by gaining knowledge about factors influencing client behaviour.	80.0%	1.06
5. Develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship.	80.0%	1.4
6. Conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and weaknesses.	78.9%	1.59*
7. Obtain appropriate continuing professional education.	80.0%	1.67*
8. Assess and participate in regular supervision and consultation sessions.	80.0%	2.0*
9. Develop and use strategies to maintain personal, physical and mental health.	80.0%	1.29
10. Establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources.	80.0%	1.33
		* Difference of greater than 1.5

Other

Since no new trends appeared in this category and the category itself contains a heterogeneous grouping, no results for this group will be presented. Results for this group are included in the common needs identified below.

What are the common needs?

Although sub-group needs are most instructive, some interesting commonalities surfaced. While the respondent groups did not always identify them as their highest priorities, the following tasks were identified unanimously by the all the sub-groups as training needs or gaps between current and desired performance levels:

Domain: Counselling

3. Assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition.
4. Provide unique individual therapy to promote a quality recovery process.
13. Acknowledge and respect cultural and life-style diversities.

Domain: Case Management

1. Maintain community referral resource information through contact with other service providers.
5. Consult with supervisors and other service providers to assure comprehensive, quality care for the client.
6. Present cases to other treatment team members.

Domain: Professional Responsibility

3. Interpret and apply information from current counselling and alcohol and other drug abuse literature.
5. Develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship.
6. Conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and weaknesses.
7. Obtain appropriate continuing professional education.
8. Assess and participate in regular supervision and consultation sessions.
10. Establish and maintain good relationships with civic groups, other professionals, government entities, and the community in general to expand community resources.

What do the respondents see as the best ways to improve on these tasks?

Part 2 of the questionnaire also asked respondents to indicate the best way to improve on each of the tasks. As very few differences were seen among the responses of the sub-groups, Table 18 summarizes the responses of all respondents. Only those tasks which were determined to be needs for at least one group using the procedure defined above are included. Responses given by over 40% of the group are in boldface type.

Table 18: Respondents' preferred methods for improving task performance

Task	Respondents saying no need to improve	Respondents saying formal training	Respondents saying on the job
Domain: Assessment			
3. Observe and document abuse/dependence for diagnosis and treatment plan.	7.9%	16.5%	75.5%
4. Match client with program.	8.1%	2.0%	89.9%
6. Recognize need for outside assessment expertise.	8.0%	9.4%	82.6%
7. Develop written diagnostic summary as basis for integrated approach to diagnosis and treatment planning.	9.1%	25.6%	64.5%
9. Formulate mutually agreed upon treatment goals, objectives and methods.	8.1%	15.4%	75.7%
Domain: Counselling			
3. Assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition.	23.4%	43.4%	32.4%
4. Provide unique individual therapy to promote a quality recovery process.	12.2%	31.1%	55.6%
6. Provide group therapy to promote growth	9.4%	70.1%	20.5%
8. Assist clients and significant others establish and maintain new behaviours in order to minimize relapse.	19.0%	80.2%	0.8%
10. Provide appropriate care and follow-up	7.5%	6.2%	85.6%
11. Assess ongoing issues and progress through review of goals and accomplishments.	7.7%	83.8%	7.7%
12. Provide information to client and significant others through written materials and other educational forums.	13.1%	46.4%	40.5%
13. Acknowledge and respect cultural and life-style diversities.	26.4%	36.3%	36.3%
15. Through case reviews, evaluate and assess counselling effectiveness.	29.3%	40.4%	28.3%
Domain: Case Management			
1. Maintain community referral resource information through contact with other service providers.	17.7%	23.8%	58.5%
2. Match community resources with client needs.	25.3%	36.3%	38.5%
3. Verbally explain to client the necessity for referral.	43.9%	21.1%	35.1%
4. Maintain client records to prescribed standards.	47.3%	24.0%	28.6%
5. Consult with supervisors and other service providers to assure comprehensive, quality care for client.	15.9%	17.2%	66.9%
6. Present cases to other treatment team members.	7.6%	1.4%	91.0%
11. Advocate for client's interests in targeted systems.	7.5%	2.1%	89.7%
14. Obtain evaluation through regular consultation with supervisors and peers, in order to assess case management techniques.	10.7%	25.2%	63.1%

Task	Respondents saying no need to improve	Respondents saying formal training	Respondents saying on the job
Domain: Education			
1. Provide relevant education to client to support the recovery process.	19.0%	**71.1%**	9.1%
2. Provide relevant education to family members and significant others to support the recovery process.	7.7%	**84.5%**	7.0%
3. Provide alcohol and drug education to the community in order to raise awareness and enhance community support.	8.5%	**74.6%**	16.2%
4. Provide drug and alcohol education and information to colleagues and other professionals to enhance professional exchange of information and to ensure continuum of care.	8.0%	8.0%	**83.2%**
Domain: Professional Responsibility			
1. Demonstrate ethical behaviours by adhering to established code of ethics.	29.9%	33.3%	36.1%
3. Interpret and apply information from current counselling and alcohol and other drug abuse literature..	17.7%	24.6%	**56.9%**
4. Recognize the importance of individual differences by gaining knowledge abut factors influencing client behaviour.	17.7%	25.4%	**56.9%**
5. Develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns maybe interfering with the counselling relationship.	10.7%	25.2%	**64.1%**
6. Conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and limitations.	9.1%	**47.1%**	**43.8%**
7. Obtain appropriate continuing professional education.	8.5%	20.8%	**70.8%**
8. Assess and participate in regular supervision and consultation sessions.	8.5%	24.0%	**67.4%**
9. Develop and use strategies to maintain personal, physical and mental health.	8.5%	20.8%	**70.8%**
10. Establish and maintain good relationships with civic groups, other professionals, government entities and the community in general to expand community resources.	9.6%	28.1%	**62.3%**

On the job training seems to be the method of choice for most of the task areas. However, for the following tasks, formal training was the method of choice for at least 40% of respondents.

Domain: Counselling

3. Assist clients and significant others use feelings to improve relationships, self-esteem and feeling recognition.
6. Provide group therapy to promote growth.
8. Assist clients and significant others establish and maintain new behaviours in order to minimize relapse.
11. Assess ongoing issues and progress through review of goals and accomplishments.

12. Provide information to client and significant others through written materials and other educational forums.
15. Through case reviews, evaluate and assess counselling effectiveness.

Domain: Education

1. Provide relevant education to client to support the recovery process.
2. Provide relevant education to family members and significant others to support the recovery process.
3. Provide alcohol and drug education to the community in order to raise awareness and enhance community support.

Domain: Professional Responsibility

6. Conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and limitations.

Table 19 below brings together the common perceived training needs for the sub-groups as summarized in Tables 12 to 16 and those which are high priority for at least one group. Those tasks which are common to all are marked as either High priority or Medium priority. For those tasks that are not common to all groups, only the High priority needs are listed.

Table 19: Common and high priority training needs for all respondent groups

Task	Admin	Program Supervisors	Health Care Workers	Counsellors	Prevention Workers	Office Workers
Domain: Assessment						
4. Match client with program.						H
Domain: Counselling						
3. Assist client and significant others use feelings to improve relationships, self-esteem and feeling recognition.	H	H	H	H	H	H
4. Provide unique individual therapy to promote a quality recovery process.	H	H	H	H	H	H
6. Provide group therapy to promote growth	H			H		
8. Assist clients and significant others establish and maintain new behaviours in order to minimize relapse.						H
13. Acknowledge and respect cultural and life-style diversities.	M	M	M	M	M	M
15. Through case reviews, evaluate and assess counselling effectiveness.			H			
Domain: Case Management						
1. Maintain community referral resource information through contact with other service providers.	H	M	H	M	M	M

Task	Admin	Program Supervisors	Health Care Workers	Counsellors	Prevention Workers	Office Workers
5. Consult with supervisors and other service providers to assure comprehensive, quality care for client.	H	M	H	M	H	M
6. Present cases to other treatment team members.	H	H	H	M	H	H
Domain: Education						
1. Provide relevant education to client to support the recovery process.		H		H	H	
2. Provide relevant education to family members and significant others to support the recovery process.					H	
3. Provide alcohol and drug education to the community in order to raise awareness and enhance community support.				H		
Domain: Professional Responsibility						
3. Interpret and apply information from current counselling and alcohol and other drug abuse literature.	M	M	M	M	M	M
5. Develop and use a range of options to explore and discuss personal feelings and concerns about clients when these concerns maybe interfering with the counselling relationship.	M	M	M	M	M	M
6. Conduct self-evaluations of professional performance to enhance self-awareness and performance by identifying strengths and limitations.	H	M	H	H	H	H
7. Obtain appropriate continuing professional education.	H	M	H	M	M	H
8. Assess and participate in regular supervision and consultation sessions.	H	H	H	H	H	H
10. Establish and maintain good relationships with civic groups, other professionals, government entities and the community in General to expand community resources.	M	M	M	M	M	M

Questionnaire Results: Part 3 - Implementation Issues

On this part of the questionnaire, respondents were asked for input regarding characteristics of potential training and incentives for taking training. Results are presented in question and answer format, showing differences by sub-group.

How important are various factors as reasons for engaging in further training?

Respondents were asked to rate potential reasons for taking further training on a 5-point scale (1=low to 5=high). Average ratings were computed for each sub-group and for the group as a whole. These averages were rank-ordered. The results of these rankings are presented in Table 20. (A rank of 1 means "most important reason", a rank of 2, "next most important", and so on. Where two reasons share the same average score, they are given tied ranks.)

Results are consistent across all groups for the two most persuasive reasons for engaging in training. The most important reason for respondents to engage in training is "to increase job skills and knowledge"; the next most important reason is "appropriate level of content". "Reputation of presenter" is important for four of the sub-groups, but "earn[ing] a credential" is important to only prevention workers, office workers and those in the "other" category.

Table 20: Rank order of importance of potential reasons for taking training

Reason	Admin	Program Supervisors	Health Care Workers	Counsellors	Prevention Workers	Office Workers	Other	TOTAL GROUP
to increase job skills / knowledge	1	1	2	1	1	1	1	1
job advancement	3	4	3	6	5	3	5	4
job mobility	5	4	4	4	6	5	4	4
earn or gain a credential	6	5	5	5	4	4	3	4
appropriate level of content	2	2	1	2	2	2	2	2
reputation of presenters/ instructors	4	3	3	3	3	6	6	3

How important are various characteristics of training?

Respondents were asked to rate the importance of various characteristics of potential training on a 5-point scale (1=low to 5=high). Average ratings were computed for each sub-group and for the group as a whole. These averages were rank-ordered. The results of these rankings are presented in Table 21. (A rank of 1 means "most important reason", a rank of 2, "next most important", and so on. Where two reasons share the same average score, they are given tied ranks.)

Results are consistent across all groups (except health care workers) for the two most important characteristics of training, which are that the training be "within convenient driving distance" and "during normal working hours". Only health care workers depart from the normal pattern choosing "classroom/seminar format" and "outside normal working hours" as most important. (However, given previous cautions about the representativeness of this group, no great significance should be attached to this variation.) The next most attractive characteristic for potential training for all except administrators and prevention workers was "in a work setting".

Table 21: Rank order of importance of training characteristics

Characteristic	Admin	Program Supervisors	Health Care Workers	Counsellors	Prevention Workers	Office Workers	Other	TOTAL GROUP
For credit	6	5	4	3	3	2	2	3
Within convenient driving distance	2	2	3	1	1	1	1	1
Classroom/ seminar format	3	4	1	4	4	2	5	3
Distance education format	4	6	5	5	6	4	6	4
In a work setting	5	3	3	3	5	3	3	3
During normal working hours	1	1	5	2	2	1	1	2
Outside normal working hours	6	7	2	5	5	5	4	4

How important are various factors as incentives for taking training?

Respondents were asked to rate the importance of various incentives for engaging in training on a 5-point scale (1=low to 5=high). Average ratings were computed for each sub-group and for the group as a whole. These averages were rank-ordered as shown in Table 22. (A rank of 1 means "most important reason", a rank of 2, "next most important", and so on. Where two reasons share the same average score, they are given tied ranks.)

Results differed somewhat across all sub-groups for this item. All groups (with the exception of the "other" category) agreed that "subsidized courses" were the most important incentive, but groups differed on what was the next most important incentive. For administrators and office workers it was "opportunity for promotion". For program supervisors, it was "time off work". For counsellors and prevention workers, it was credit towards a certificate, diploma, or degree. For the overall group, "subsidized courses" and "credit towards a certificate, diploma, or degree" were the most important incentives.

Table 22: Rank order of importance of factors as incentives for taking training

Incentive	Admin	Program Supervisors	Health Care Workers	Counsellors	Prevention Workers	Office Workers	Other	TOTAL GROUP
time off work	3	2	5	5	4	3	4	5
subsidized by employer	1	1	1	1	1	1	3	1
continuing education credits	5	4	2	3	3	4	1	3
certificate, diploma, or degree credits	4	3	3	2	2	3	2	2
opportunity for promotion	2	3	4	4	5	2	5	4

Would respondents take advantage of prior learning assessment?

Overall, 74.5% of the respondents indicated they would take advantage of prior learning assessment "even if I were required to compile an extensive paper/portfolio to document my prior learning". The only sub-group to deviate from this pattern was office workers, 56.3% of whom still responded positively to this question.

Other Comments

Of the 149 respondents, fifty-four included written responses to the final question, "What else would you like to tell us about y ing needs and how to meet them?" Content analysis of these responses yielded nine categories in which more than two responses were the same:

Comment	# of occurrences
more computer training	4
on the job training best	4
more workshops	3
more training in administrative duties	3
need to standardize duties with credentials	3
discussion groups good	3
more formal 'in class' training	3
more money for in house training	3
more money for university upgrading	3

Results From Content Analysis

The role delineation study used as a basis for this study provides a summary of component knowledge and skills for each of its fifty-five given tasks. Appendix C lists in full the knowledge and skill components for each of the twelve tasks that were identified by this study's respondents as high priority training needs. (See Table 19. The Assessment task identified as a high priority only by office workers has not been included in this analysis.)

However, simply describing a task and its components does not necessarily provide direction for training. In order to develop logical groupings of knowledge and skill components which could be used to develop and/or validate training possibilities, the project team re-sorted the knowledge and skill components for the twelve tasks identified as high priority training needs and organized them into more educationally meaningful modules. Analysis of these components revealed many overlaps and duplications - a specific knowledge or skill was frequently given as a component of more than one task. These overlaps and duplications proved to be valuable indicators of ten logical groupings, which are given below.

Grouping 1: Communication, Counselling and Treatment Skills

Requires knowledge of:

- a range of feeling words.
- the normal range of affect.
- advantages and disadvantages of awareness and expression of feelings.
- human needs and motivation
- interpersonal dynamics and needs.
- intrapersonal dynamics.
- interview processes, including objectives, stages, and techniques.
- assertiveness techniques.
- positive coping skills
- use of feedback to the client.
- methods of providing various forms of reinforcement to the client.
- a range of productive coping skills and problem solving techniques.
- stages of grief and grief resolution.
- behavioural contracting.
- methods of responding to a client in crisis.
- the effects of the psychoactive drugs on affective states.
- various therapy approaches relevant to alcohol and drug abuse counselling
- determining therapy approach appropriate to client needs.
- phases of treatment and client responses (i.e., crises, impasses, plateaus, resistance, etc.)
- the utility of defense mechanisms for the client and appropriate counselling approaches.
- the various manifestations of denial as it relates to the client's use, misuse, abuse and dependence on alcohol and/or other drugs.
- issues related to boundary setting.
- transference and countertransference issues.
- evaluation techniques to determine therapy effectiveness.

Requires skills in:

- appropriate expression of feelings.
- focusing on the here and now.
- identifying and interpreting verbal and non-verbal behaviour.
- observing and responding to unstated feelings.

- utilizing appropriate self-disclosure.
- active and empathic listening.
- appropriate empathic response.
- giving both positive and negative feedback.
- furthering responses or eliciting information and feedback.
- obtaining, organizing, and analysing feedback.
- summarizing and checking for accuracy.
- teaching and modelling problem-solving skills and options.
- exploration of options, attitudes, and new behaviours.
- therapeutic communication (i.e., reflecting, clarification, paraphrasing, reframing, confrontation, etc.)
- analysing data to determine therapy approach.
- selecting and providing appropriate therapy approaches.
- focusing on current, relevant issues.
- techniques to assist clients in learning appropriate expression of feelings.
- recognizing client resistance.
- modelling appropriate boundary setting.
- techniques in self-esteem building.
- identifying inconsistencies in values and behaviour.
- recognizing and responding to congruency and non-congruency in the therapy process.
- demonstrating acceptance of the individual while confronting the non-productive behaviours.
- timing of interventions in interactions.
- determining relevant task assignments appropriate to different therapeutic stages.
- explaining the role and purpose of education in the treatment process.
- termination of the counselling process with the group or an individual member.

Grouping 2. Addiction Processes and Consequences

Requires knowledge of:

- the stages of human development.
- legal limits on blood alcohol content (BAC).
- effects of blood alcohol content (BAC) on behaviour and state of arousal.
- states of intoxication, withdrawal, and long term effects of alcohol and other drug use.
- patterns and methods of misuse and abuse of prescribed and over-the-counter medications.
- criteria for evaluating alcohol and other drug use, misuse, abuse and dependence.
- behaviour, patterns, and progressive stages of alcohol and other drug abuse/ dependence.
- consequences of the misuse of alcohol and drug dependency on family systems, significant others, and the community.
- the effects of alcohol and other drug use/abuse on nutrition and proper eating habits.
- chemical dependency problems in the community.
- trends in street and designer drugs.
- significance of diagnostic reports from laboratory studies (e.g., blood, urine, saliva, EEG tests).
- adverse effects of combining various types of psychoactive drugs, including alcohol.
- potential for cross addiction when psychoactive drugs are taken.
- addiction substitution.
- cognitive and behavioural changes to support recovery.

Grouping 3: Treatment Planning and Case Management

Requires knowledge of:
- the treatment planning process.
- expected rates of progress in recovery.
- federal, provincial, and local laws related to alcohol and drug use, possession, distribution, and behaviour.
- risk factors that relate to potential suicide, homicide, family violence, self injury, and other violent and aggressive behaviours.
- the dynamics of relapse.
- multi-disciplinary team functions.
- how to identify needs for clinical or technical assistance.
- agency's policies regarding case consultation.
- how to network with other professionals.
- how to develop and present a comprehensive case structure.
- how to present client cases to supervisor or other professionals.
- how to interpret and integrate consultation results.

Requires skills in:
- assembling and analysing data for case consultation.
- evaluating peers' feedback relative to your own knowledge of the case.
- selecting/adapting treatment approaches to the feedback received from others.

Grouping 4: Written and Oral Communication

Requires knowledge of:
- oral/written communication.
- how to write/present/develop a case presentation.

Requires skills in:
- organizing client information for presentation to others.
- making clear, concise, oral case presentations.
- writing clear, concise, comprehensive case studies.
- interpreting written reports of other professionals.
- reading and interpreting professional literature.

Grouping 5: Referral and Resources

Requires knowledge of:
- the continuum of care.
- community resources in alcohol and drug abuse treatment.
- referral rationale for group counselling and individual counselling.
- services provided within the community and necessary referral information.
- skills/services provided by other professionals.
- the range of self-help fellowship available to the community.
- the services available to clients in the areas of child care and parenting, especially as they affect access to treatment and other services.
- follow-up process with referral sources.
- differences found in special populations (e.g., cultural, ethnic, and racial minorities; handicapped populations; special populations identified by age, gender, sexual orientation, etc.) and how differences affect assessment and response to treatment.

Requires skills in:
- assessing client's needs and matching them to outside resources.
- networking/interacting with outside resources.
- observing and responding to feedback from other professionals.

Grouping 6: Ethics and Professional Standards

Requires knowledge of:
- professional terminology.
- professional scope of practice.
- ethical standards which apply to alcohol/drug abuse counselling.
- professional standards which apply to alcohol/drug abuse counselling.
- regulatory guidelines and restrictions relating to alcoholism/drug treatment and counselling.
- legal issues and related professional standards.
- the consequences of disregarding proper professional standards.
- legal confidentiality requirements.
- requirements regarding the mandatory reporting of child abuse.
- federal, provincial, and local laws related to alcohol and drug use, possession, distribution, and behaviour.
- the importance of regular assessment of professional skills and development.

Requires skills in:
- time management.
- interpreting and applying ethical, legal, and professional standards.
- developing professional goals and objectives.
- identifying personal and agency limitations.
- identifying one's own professional progress and limitations.

Grouping 7: Working with Groups

Requires knowledge of:
- different types of groups, their purposes, functions, and parameters.
- developmental stages of groups.
- impact on group of factors such as size, frequency, duration, and admission of new members.
- theories related to group membership and rules as related to group purpose.
- individual behaviour as it impacts on group process.
- varying group leader roles and styles.
- a variety of group techniques, their purposes, and consequences.
- therapeutic factors in group therapy (universality, altruism, collective family experience).

Requires skills in:
- basic tasks in creation and maintenance of a group.
- preparing the chemically dependent person for group.
- communicating differences between group therapy and twelve step groups.
- establishing an environment to support trust among group members.
- developing cohesiveness among group members
- culture building in group.
- focusing on interaction among group members with attention to the here and now.

- making process comments appropriate to the developmental stage of the group.
- dealing with membership problems (turnover, dropout).
- dealing with group behaviours such as subgrouping, conflict, and self-disclosure.
- utilizing conflict in group for individual and group growth.

Grouping 8: Clinical Supervision

Requires knowledge of:

- one's personal strengths and limitations.
- the importance of self-evaluation.
- the value of case consultation.
- the importance of soliciting peer input.
- the value of consultation to enhance personal and professional growth.
- self-evaluation techniques.
- clinical supervision models.
- one's personal strengths and limitations.
- one's professional strengths and limitations.
- strengths and limitations of one's own work setting.
- stress management.

Requires skills in:

- assertiveness.
- openly communicating need for assistance.
- soliciting feedback from others.
- utilizing appropriate self-disclosure.
- accepting both constructive criticism and positive feedback.
- giving both positive and negative feedback.
- differentiating between facts, feelings and impressions.
- recognizing peers' strengths and limitations.
- recognizing personal strengths and limitations.
- identifying one's own professional progress and limitations.
- utilizing self-assessment for personal and professional growth.
- identifying and utilizing sources of supervision and consultation.
- eliciting and utilizing feedback from colleagues and supervisors.
- mediating conflict.

Grouping 9: Working with Multi-needs Individuals

Requires knowledge of:

- the relationship between alcohol and other drug abuse and various cultures, values, and lifestyles.
- differences found in special populations (e.g., cultural, ethnic, and racial minorities; handicapped populations; special populations identified by age, gender, sexual orientation, etc.) and how differences affect assessment and response to treatment.
- signs and symptoms of mental and personality disorders and implications for treatment and referral.
- correlation between alcohol and other drug abuse/dependence and specific mental disorders such as mood disorders, anxiety disorders, and schizophrenia.
- sexual dysfunctions, including compulsive sexual behaviours.

- the relationship between alcohol and other drug use, abuse, and dependence and sexual function.
- sexually-transmitted diseases and their relation to alcohol and other drug abuse.
- correlation between alcohol and other drug abuse/dependency and childhood trauma, including physical, emotional, and sexual abuse.

Requires skills in:
- conveying respect for cultural and lifestyle diversity.

Grouping 10: Working with Families

Requires knowledge of:
- the effects of addiction on society and the family.
- family systems.
- family and environmental processes that inhibit or promote expression of feelings.
- historic and generational influences on alcohol and drug abuse/dependence (i.e., family of origin, ACOA issues, etc.)
- how peer influence encourages or discourages alcohol and/or other drug use, abuse, or dependence.
- signs, symptoms, and patterns of domestic violence.

Results from Focus Group

Key points from the supervisors' focus group convened to discuss minimum requirements for working in the system of care, are summarized below. (For a detailed report see Appendix D.)

The group stated that *prevention workers* should have a Bachelors degree and an understanding of how to structure educational programs. They felt that in reality these workers often have less in the way of formal educational qualifications than do others within the system.

The participants determined that *counsellors* should have a Bachelors degree in a social science field with 5-7 years experience, or a Masters degree in a social science field with 2-5 years experience, plus:

- an in-depth framework for understanding substance abuse;
- generic counselling skills;
- an appreciation of the current abuse crisis; and
- an understanding of how to structure educational programs.

The focus group also identified that *counsellors working in residential settings* need training in survival first aid and CPR.

They felt more open to alternative qualifications for *counsellors working in supportive recovery centres*. Examples of these alternative qualifications included two years in recovery, one year related work experience, an LPN designation, or a one- to two-year social service certificate/ diploma.

The results of the focus group's discussion of required qualifications for *health care workers* were unclear, but the general impression was left that alternative qualifications such as those discussed in the previous paragraph would be appropriate.

The group felt that required qualifications for *administrators* were similar to those for counsellors, namely, a Bachelors or Masters in a relevant field, an in-depth framework for understanding substance abuse, and generic counselling skills. In addition, it was felt that administrators needed:

- training in clinical supervision, team management, and organizational skills;
- experience in working with boards, the community, and funding agencies;
- experience with program design and evaluation;
- experience in labour relations; and
- public speaking skills.

Program supervisors were not dealt with as a separate category by the focus group, perhaps because the group felt that their input regarding administrators was sufficient.

The focus group did not deal with qualifications for *office workers*.

Conclusions by Key Question

In this section, the results from the various data sources are synthesized to shed as much light as possible on the key questions which guided the needs assessment study. Conclusions are presented by question. The first two questions are presented together to aid in synthesis.

1. ***What is the basic minimum requirement to work in each setting?*** and

2. ***What is the current level of qualifications of workers in the system of care?***

Very few differences by setting were found between the sets of tasks worker groups reported performing. In the focus group, supervisors expressed the belief that alternative qualifications were more acceptable in supportive recovery centres. However, since 41.8% of the questionnaire sample came from outpatient services, with the remainder spread over the other categories of settings, cell sizes were too small to allow for any conclusions to be drawn regarding differences between settings and the research is unable to confirm the belief expressed at the supervisors focus group. Different qualifications for job categories are more obvious and are explained below with reference to qualifications, years of experience, and tasks performed on the job.

Administrators and Program Supervisors

Supervisors in the focus group thought administrators should have a Bachelors or higher degree and questionnaire results show that 55% do. Another 35% have a college certificate or diploma. Administrators are an experienced group; 75% have worked in the field for 6 or more years. The situation is very similar for program supervisors, with 72% of them having university degrees and 63% of them having 6 years or more of experience in the field.

Health Care Workers

It is unwise to draw conclusions for health care workers since the response rates on the questionnaire for this group was low.

Counsellors

The supervisors in the focus group thought counsellors should have a Bachelors or higher degree with 2 to 7 years of experience. Questionnaire results show that 61% of counsellors do have university degrees, and an additional 23% have college certificates or diplomas. Counsellors have fewer years of experience than administrators, with 53% in the 2 to 5 year range and 36% having worked in the field for 6 or more years.

Prevention Workers

The supervisors in the focus group thought prevention workers should have a Bachelors degree. Questionnaire results show that 44% do have Bachelors degrees, and an additional 19% have more advanced university work including advanced degrees. Another 19% have college certificates or diplomas. Prevention workers are newer to the field; 56% have only 2 or 3 years of experience.

Office Workers

Office workers tend to have high school or college level training. The majority have worked in the alcohol and drug field 2 to 5 years.

The analysis of the tasks they perform is confusing. They report performing a high proportion of the Assessment, Counselling, and Case Management tasks. It is possible that office support workers assist with these tasks rather than perform them independently and that their pattern of responses may have been influenced by the design of the questionnaire. However, it is also possible that in smaller, more remote areas, office workers handle more of these tasks because they are the people on the front line when clients need help. If that is the case, then they need training in areas which may not previously have been obvious.

3. *What are the gaps between current level and desired level, as per role delineation study?*

See Table 19 for a summary of all respondents' perceived training needs, or gaps between current and desired levels of performance.

It appears from this analysis that training in the Assessment tasks is a priority need for only office workers.

Within the Counselling domain, individual and group counselling techniques are critical training needs. Multicultural education and training for dealing with client diversity are moderately strong needs of all groups.

Within the area of Case Management, the need to remain current with community resources is moderately high with most groups and high with administrators. Also within Case Management, there is a strong need to confer on cases as part of a treatment team. Meeting this need will require not only training but also potentially a change in the way agencies currently operate.

Needs in the Education domain seem to be specific to certain sub-groups.

However, all groups identify strong needs in the Professional Responsibility domain, which taken together seem to represent a strong cry for greater professional development in the field. All groups want help with keeping current on the literature, and examining their own practice vis a vis legal, ethical, and personal issues in the treatment process. In addition, they see needs for continuing education, regular supervision and consultation sessions, and greater involvement in the community.

4. *What are the topic areas of training needed, including areas of specialization?*

This is probably the most complex of the key questions. In order to arrive at some answers, the project team reviewed previous needs analyses for common identified needs, and then examined the knowledge and skill breakdowns for each of the tasks identified as high priority training needs by the current study's respondents. See pages 47 to 52 for detailed information on the ten groupings which emerged from this process: Communication, Counselling and Treatment Skills; Addiction Processes and Consequences; Treatment

Planning and Case Management; Written and Oral Communication; Referral and Resources; Ethics and Professional Standards; Working with Groups; Clinical Supervision; Working with Multi-needs Individuals; and Working with Families.

We believe that some of these components given on pages 47 to 52 are entry level knowledge or skills, which would ideally be acquired in pre-service training. Educators who work further with these grouped topic outlines will need to consider their specific target group's current level and assess which components it is necessary to address. Cross referencing the task components given in Appendix C with the ten groupings prove to assist in this process.

5. *What is the favoured mode of delivery?*

As shown in Table 18, questionnaire respondents prefer on-the-job training for most needs, specifically the Assessment tasks, some of the Counselling tasks, all of the Case Management tasks, and most of the Professional Responsibility tasks. This reinforces the findings from previous studies that there is a strong desire for supervised skills practice (coaching with feedback or clinical supervision) in the workplace.

Some components lend themselves to on-the-job training, others may require more formal training. The educational designer should keep in mind both the desires of the respondents as summarized in Table 18 and the principles of sound instructional design.

The most critical characteristics of the training are that it be "within convenient driving distance" and "during normal working hours". In contrast to participants in previous needs assessments, respondents showed little interest in distance education. Rather, it seems that a more traditional approach is preferred, which reinforces previous findings that short courses or workshops are the method of choice. It appears, however, that these short courses or workshops must be delivered in the regions rather than at centralized locations.

In addition, the respondents would like the training system to provide them an opportunity to gain credit for prior learning (PLA) even if they were required to document extensively that learning.

7. *What are the incentives in the system for people to upgrade skills and knowledge?*

Results from the questionnaire indicate that workers in this field are motivated to take training if it will "increase [their] job skills and knowledge" and if the level of content is appropriate to their needs. They also look carefully at the reputation of the instructors. In other words, these potential trainees are selective and careful consumers of training; they will "shop around".

In addition, the most important incentive for taking training for all groups was that those courses were subsidized by the employer. Although results regarding credit were mixed, credit toward a certificate, diploma or degree appears to be important primarily for counsellors and prevention workers. For administrators and office workers, training that leads toward opportunities for promotion was more important.

Recommendations

1. That no more effort be expended on conducting needs analyses. This study confirmed the findings of most previous work. Further analyses would not reflect the most effective allocation of scarce resources.

2. That significant resources be committed to *coordinated, provincial, in-service* training courses and programs, which would be delivered on paid time, near the place of work (perhaps regionally), with costs (including employee replacement costs) subsidized by the employer. Training content should be based on the needs identified in this study and in other recent provincial needs assessments.

3. That short term training efforts focus primarily on:
   - individual, group, and family counselling skills identified by this study
   - training in clinical supervision (for both supervisors and those supervised)
   - ethics and professional standards
   - methods to facilitate individual and group learning
   - working with multi-needs individuals

4. That an in-service professional development system be implemented which requires that professional development plans be filed annually by individual workers, and then commits funding that assists workers to address the components of their plans which are compatible with the goals of the organization and of the system of care.

5. That agencies be made accountable for the professional development funding they receive, and that they be required to spend a certain proportion of this funding on programs which bring the agency's employees together for training.

6. That ways be found to allow the employees who work together in an agency to have time for group professional development aimed at enhancing their ability to work together in treatment teams.

7. That the coordinated, provincial, in-service training strategy include sessions specifically designed to allow personnel from several local social service agencies to train together in order to enhance all parties' skills in working in multidisciplinary teams.

8. That creative methods of distance delivery form part of the training strategy, but only where appropriate to the content or objectives.

9. That an attempt be made to clarify the role of office workers and that appropriate training consistent with the tasks they are expected to perform be provided for them.

10. That a system of clinical (practical) supervision, by qualified supervisors, be implemented. Successful implementation would require training both for those who are supervised and for supervisors; it may also require changes to the working environment to allow clinical supervision to take place. By clinical supervision is meant: "an area of staff development that deals with the clinical skills and competencies of staff, including discussions and analyses of problems encountered and the individual needs of the client and worker. The process focuses upon what workers need to 'know and do' in order to provide treatment services to specific clients." (from *Substance Abuse Curriculum Resources: Assessment and Referral*, p.317)

11. That individuals, organizations, and the system as a whole use the resources identified in *Inventory of Substance Abuse Training Resources* (companion publication to this one) to meet their training needs. Individuals could seek out courses and workshops to meet individual needs. Organizations and the system as a whole could negotiate for large-scale training in areas of common need, using economies of scale to achieve cost-effectiveness.

12. That a certification system similar to those systems used in education or nursing be implemented. The certification could be part of a national system such as that administered by the Addictions Intervention Association, which certifies practitioners as CADC's (Certified Alcohol and Drug Counsellor) and ICADC's (International Certified Alcohol and Drug Counsellor). This system would ideally incorporate a code of ethics, require examination of competency for entry, allow for recognition of skills already learned, and require ongoing professional development. Respondents consistently identified a need for increased professionalism.

13. That the field's stated need for increased professionalism also be addressed by the Ministry of Health encouraging the Ministry of Skills, Training and Labour to fund pre-service certificate, diploma and degree programs for people who will work with clients who abuse substances. Such programs, which ensure a supply of well-trained professionals and paraprofessionals, are not currently funded by the Ministry of Skills, Training and Labour.

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Appendices

Appendix A

Questionnaire

October 19, 1993

Dear Alcohol and Drug Programs Worker,

As you may know, ADP has asked the University College of the Fraser Valley and the University College of the Cariboo to undertake an assessment of the training needs of alcohol and drug workers in BC. As part of our strategy, we are contacting a sample of people who work in this field and asking them to fill in and return to us the attached questionnaire. We are not contacting everyone, only a sample, so it is very important to us that you complete and return the questionnaire **before November 12, 1993**. We have provided a stamped, self-addressed envelope to facilitate this. All responses will be kept strictly confidential.

Most of the items on the questionnaire are very straightforward. However, for Part 2 a little extra explanation might be helpful. We are asking you to respond on several scales to each of 54 tasks. These tasks were derived from a study of the role of alcohol and drug workers across the US; this task breakdown has been revised for use locally by the Advisory Committee to this project.

For each task, we ask you to respond in four ways:

1. Indicate whether or not this task is a **requirement** for your particular job. If it is not a part of your job, choose **not applicable** (n/a). You may then choose not to respond further to that particular task.

2. Rate your **current level of ability** on the task, 1 being low and 5 being high.

3. Indicate your **desired level of ability** on the task, 1 being low and 5 being high.

4. In the last column, indicate whether you feel you could improve most in this task by **on the job experience**, or **formal training**; you may choose **no need to improve** if you have no need to improve in this area.

In addition, if a task which is an important part of your job is not included, please add and rate it on page 8.

We thank you in advance for taking the time to fill in our questionnaire and we appreciate your getting it back to us as soon as possible. If you have any questions, please contact Marg Penney at 875-1579.

Sincerely,

The Project Team

Alcohol and Drug Workers Questionnaire

The ADP Project

By taking a few minutes to complete this questionnaire, you will be providing important information which ADP can use in planning to meet the training needs of alcohol and drug workers. For each question please circle the most appropriate response, or write your response in the space provided. Please select only one response to each question, unless otherwise indicated.

PART I

1. Which of the following best describes your current work?

   1. administrator
   2. program supervisor
   3. health care worker (detox)
   4. counsellor
   5. prevention worker
   6. office support worker / office manager
   7. other (please specify) _____

2. Which of the following is the primary setting in which you work?

   1. residential treatment facility
   2. supportive recovery home
   3. outpatient / non-residential service
   4. detox centre
   5. hospital
   6. school
   7. other (please specify) _____

3. Which of the following best describes your work?

   1. generalist
   2. specialist

   If a specialist, select up to 3 specialties:

   1. adolescents
   2. women
   3. elderly
   4. First Nations persons
   5. families
   6. dual diagnosis
   7. other (please specify) _____

4. What is the highest level of education you have completed?

   1. less than high school
   2. high school
   3. some college or university courses
   4. college certificate or diploma
   5. Bachelor's degree
   6. university - some post-graduate work
   7. post-graduate degree (Masters or PhD)

5. Do you have any of the following professional designations / credentials? Circle all that apply.

   1. RSW
   2. RCC
   3. RN
   4. RNA
   5. RPN
   6. Registered Psychologist
   7. MD
   8. CADC
   9. Professional Teacher's Certificate
   10. other (please specify)

   _____

6. How long have you been working in the alcohol and drug field?

   1. less than 1 year
   2. 2 - 3 years
   3. 3 to 5 years
   4. 6 to 9 years
   5. 10 years or more

7. Which of the following best describes the agency for which you work?

   1. a direct service of ADP
   2. an agency directly funded by ADP
   3. an agency funded by NNADAP
   4. an agency not funded by ADP
   5. other (please specify) _____

8. In which of the ADP regions do you work?

   1. Region 1 - Lower Mainland
   2. Region 2 - Fraser Valley
   3. Region 3 - Thompson-Okanagan/Kootenays
   4. Region 4 - North
   5. Region 5 - Vancouver Island, Gulf Island and Central Coast

9. What % of your working time is devoted to:

   1. assessment and referral _____%
   2. counselling _____%
   3. prevention/public education _____%
   4. management _____%
   5. clerical/report writing _____%
   6. agency liaison work _____%
   7. other (please explain) _____%

   _____

PART 2 Directions: For each of the following tasks, please circle the appropriate response. For the number scales, 1 = a very low level of ability, 2 = a low level, 3 = a moderate level, 4 = a high level, and 5 = a very high level of ability.

Domain: **ASSESSMENT** Tasks:	**Requirement** for my job?	My **CURRENT** level of ability: LOW HIGH	My **DESIRED** level of ability: LOW HIGH	The best way to improve in this task is: (circle one only)
1. Using interview techniques, gather relevant information from the client in order to obtain current status and history.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
2. Gather and evaluate information from sources other than the client, utilizing client-consented interviews and/or written reports, to validate his/her reports and provide a more complete history.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
3. Observe and document psychological, social and physiological signs and symptoms of alcohol and other drug abuse and dependence in the client to make an accurate diagnosis and formulate a treatment plan.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
4. Determine the client's appropriateness and eligibility for admission or referral to a range of programs by assessing the match between the client's needs and program target populations and services.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
5. Request from the client appropriately signed releases when soliciting from or providing information to outside sources to protect client confidentiality.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
6. Recognizing signs and symptoms that indicate a need to refer the client for additional professional assessment services when such assessment is outside the areas of the counsellor's expertise.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
7. Develop a written diagnostic summary based on the results of separate assessments performed by an alcohol and drug abuse counsellor and/or a multi-disciplinary team including physical/chemical use/abuse history, psychological, psychiatric, social, spiritual, recreational, nutritional, educational, vocational and/or legal information to provide an integrated approach to diagnosis and treatment planning.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
8. Document ongoing treatment needs identified by regular assessments performed throughout the continuum of care and negotiate adjustments to the treatment plans to assure new treatment needs are addressed.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
9. Formulate mutually agreed upon goals, objectives, and treatment methods based upon assessment finding of the client's strengths, weaknesses, needs and problems for the purpose of directing a course of treatment.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job

Domain: ASSESSMENT Tasks:	Requirement for my job?	My CURRENT level of ability: LOW HIGH	My DESIRED level of ability: LOW HIGH	The best way to improve in this task is: (circle one only)
10. Select, administer, score and interpret to clients the results of assessment instruments in order to provide accurate, standardized measurements of data relating to the clients' problems.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
11. Explain the purpose, rationale and methods associated with the assessment process to the client to assure understanding and compliance.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job

Domain: COUNSELLING Tasks:	Requirement for my job?	My CURRENT level of ability: LOW HIGH	My DESIRED level of ability: LOW HIGH	The best way to improve in this task is: (circle one only)
1. Establish rapport and trust with client, family members and related systems by providing a safe environment in order to facilitate self-exploration, disclosure, problem solving and interaction	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
2. In the initial counselling session, provide specific information to the client regarding the structure, expectations and limitations of the counselling process in order to promote a trusting relationship; and assist the client in decision-making regarding the treatment process.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
3. Assist the client, family members and significant others in identification, clarification and expression of feelings by teaching, modelling and interacting in order to improve relationships, self-esteem and feeling recognition.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
4. Provide individual therapy, using relevant and current client data with an appropriate therapeutic approach to meet the client's needs, problems, strengths and weaknesses to promote a quality recovery process.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
5. Provide family therapy with client and/or significant others within a conducive setting to promote individual and system growth.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
6. Provide group therapy by modelling, directing and facilitating developmental stages within the group in order to promote growth.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job

Domain: COUNSELLING Tasks:	Requirement for my job?	My CURRENT level of ability: LOW HIGH	My DESIRED level of ability: LOW HIGH	The best way to improve in this task is: (circle one only)
7. Identify group, purpose, rules, goals and membership criteria for group members through formal and informal means to facilitate interaction and communication.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
8. Assist clients, family members and significant others in establishing and maintaining new behaviours or changes in behaviour in order to minimize relapse through teaching, modelling and other counselling techniques.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
9. Intervene in life crisis situations with client or significant others in order to prevent or cope with that crisis by utilizing needed resources and identifying and teaching new skills.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
10. Provide care and follow-up appropriate to the client's needs after the initial phase is completed utilizing a variety of approaches.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
11. Assess ongoing issues and related progress with clients, family and significant others in order to promote growth through periodic review of goals and accomplishments.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
12. Provide current and accurate information and education to client, family members and significant others through written materials and other educational forums in order to prevent initiation or progression of alcoholism and drug dependency.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
13. Acknowledge and respect cultural and life-style diversities as they relate to emotional, spiritual and physical health with all clients, family members and significant others to affirm differences through accepting attitudes and behaviours.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
14. Assist clients, family, and significant others in the recognition of the role of defense mechanisms (especially denial and minimization) through confrontation, teaching and eliciting feedback, in order to further the recovery process.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
15. Evaluate and assess through case reviews the effectiveness of the chosen counselling approaches and processes to ensure quality.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job

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Domain: CASE MANAGEMENT Tasks:	Requirement for my job?	My CURRENT level of ability: LOW HIGH	My DESIRED level of ability: LOW HIGH	The best way to improve in this task is: (circle one only)
1. Obtain and maintain information about community resources and services by establishing contact with other service providers in order to evaluate the appropriateness of referring the client.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
2. Match the community resources with client needs in order to improve the effectiveness of treatment by paying particular attention to cultural and life-style characteristics of clients.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
3. Verbally explain to the client the necessity for referral in order to ease the transition to other service providers.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
4. Demonstrate proficiency in maintaining client record in accordance with prescribed standards to ensure thorough documentation.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
5. Consult with supervisors, counsellors, professionals and/or other service providers by discussing one's own case to assure comprehensive, quality care for the client.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
6. Present cases to other treatment team members in order to facilitate decision making and planning by using a written or oral method.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
7. Assist other treatment team members by providing alternative input on their cases in order to develop comprehensive, quality care for the client.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
8. Verbally explain to the client the need for consultation and obtain written consent when needed in order to provide quality care.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
9. Provide a program overview to the client by describing goals, objectives, rules and obligations in order to agree upon mutual expectations.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
10. Provide education for the client about self-help groups by supplying appropriate information in order to encourage participation.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job

Domain: CASE MANAGEMENT Tasks:	Requirement for my job?	My CURRENT level of ability: LOW HIGH	My DESIRED level of ability: LOW HIGH	The best way to improve in this task is: (circle one only)
11. Advocate for client's interests in targeted systems by negotiating plans in order to help resolve client's problems.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
12. Provide information through appropriate contacts with outside agencies in order to ensure adequate funding for services provided.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
13. Maintain through regular communication a network of community resources in order to enhance client's treatment.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
14. Obtain evaluation through regular consultation with supervisors and peers in order to assess case management techniques.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job

Domain: EDUCATION Tasks:	Requirement for my job?	My CURRENT level of ability: LOW HIGH	My DESIRED level of ability: LOW HIGH	The best way to improve in this task is: (circle one only)
1. Provide relevant education to the client through formal and informal processes to introduce specific knowledge to support the recovery process.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
2. Provide relevant education to family members and significant others through formal and informal processes to introduce specific knowledge to help support the recovery process.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
3. Provide alcohol and drug education to schools, service clubs, business, industry and labour, media representatives, political and community leaders and other significant persons to raise awareness and enhance community support.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
4. Provide drug and alcohol education and information to colleagues and other professionals via lectures, discussions and meetings to enhance professional exchange of information and ensure continuum of care for the client.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job

Domain: PROFESSIONAL RESPONSIBILITY Tasks:	Requirement for my job?	My CURRENT level of ability: LOW HIGH	My DESIRED level of ability: LOW HIGH	The best way to improve in this task is: (circle one only)
1. Demonstrate ethical behaviours by adhering to established professional codes of ethics in order to maintain professional standards and safeguard the best interests of the client.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
2. Adhere to federal, provincial and agency regulations regarding alcohol and other drug abuse treatment by following appropriate procedures to protect client rights.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
3. Interpret and apply information from current counselling and alcohol and other drug abuse literature to improve client care and enhance professional growth.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
4. Recognize the importance of individual differences by gaining knowledge about personality, cultures, life-styles and other factors influencing client behaviour in order to provide services that are sensitive to the uniqueness of the individual.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
5. Develop and utilize a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
6. Conduct self-evaluations of professional performance applying ethical, legal and professional standards to enhance self-awareness and performance by identifying strengths and limitations.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
7. Obtain appropriate continuing professional education by ongoing assessment of one's own training needs in order to promote professional growth.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
8. Assess and participate in regular supervision and consultation sessions to facilitate clinical and administrative growth.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
9. Develop and utilize strategies to maintain personal, physical and mental health in order to ensure professional effectiveness.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
10. Establish and maintain good relations with civic groups, other professionals, government entities and the community in general through open communication and supportive involvement to expand community resources.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job

Domain: Tasks:	**Requirement** for my job?	My **CURRENT** level of ability: LOW HIGH	My **DESIRED** level of ability: LOW HIGH	The best way to improve in this task is: (circle one only)
1.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
2.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
3.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
4.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
5.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
6.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
7.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
8.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
9.	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job
10. 80	yes no n/a	1 2 3 4 5	1 2 3 4 5	1. no need to improve 2. formal training 3. on the job

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PART 3

Please circle the most appropriate response, or write your response in the space provided.

1. How important would <u>each</u> of the following be as a reason for your taking further training?	not important	LOW			HIGH	
1. to increase my skills and knowledge	0	1	2	3	4	5
2. job advancement	0	1	2	3	4	5
3. job mobility	0	1	2	3	4	5
4. earn or gain a credential	0	1	2	3	4	5
5. reputation of presenters / instructors	0	1	2	3	4	5
6. appropriate level of content	0	1	2	3	4	5
7. other (please specify) _____	0	1	2	3	4	5

2. How important is it for you that training is	not important	LOW			HIGH	
1. for credit	0	1	2	3	4	5
2. within convenient driving distance	0	1	2	3	4	5
3. in a classroom / seminar format	0	1	2	3	4	5
4. in a distance education / correspondence format	0	1	2	3	4	5
5. in a work setting (ie. clinical supervision)	0	1	2	3	4	5
6. during normal working hours	0	1	2	3	4	5
7. outside of normal working hours	0	1	2	3	4	5
8. other (please specify) _____	0	1	2	3	4	5

3. How important are <u>each</u> of the following as incentives for you to take part in training?	not important	LOW			HIGH	
1. time off from work	0	1	2	3	4	5
2. courses subsidized or paid for by your employer	0	1	2	3	4	5
3. continuing education credits	0	1	2	3	4	5
4. credits towards a certificate, diploma or degree	0	1	2	3	4	5
5. opportunity for promotion	0	1	2	3	4	5
6. other (please specify) _____	0	1	2	3	4	5

4. Some programs offer the opportunity for students to challenge program components if they can demonstrate that they have learned some skills/knowledge on the job. This is called prior learning assessment (PLA). What is your position on prior learning assessment?

   1. I would take advantage of prior learning assessment even if I were required to compile an extensive paper / portfolio to document my prior learning
   2. I would not take advantage of prior learning assessment

5. What else would you like to tell us regarding your training needs, and how to meet them?

_____

_____

_____

Appendix B

Summary of Respondents' Self-Ratings on Job Requirements

Appendix B gives, by job category, the questionnaire respondents' self-ratings on their current performance of the role delineation study's component tasks. Average self-ratings are given only for those tasks which 50% or more of the respondents in the job category indicated were a requirement for their jobs.

Domain: **ASSESSMENT** Tasks:	Current Self-Ratings by Respondent Category:						
	AD	**PS**	**HC**	**CN**	**PW**	**OF**	**O**
1. Using interview techniques, gather relevant information from the client in order to obtain current status and history.	4.1	4.0	4.2	4.0	4.0	4.1	4.1
2. Gather and evaluate information from sources other than the client, utilizing client-consented interviews and/or written reports, to validate his/her reports and provide a more complete history.							
3. Observe and document psychological, social and physiological signs and symptoms of alcohol and other drug abuse and dependence in the client to make an accurate diagnosis and formulate a treatment plan.		3.3		3.5	3.7	3.5	3.5
4. Determine the client's appropriateness and eligibility for admission or referral to a range of programs by assessing the match between the client's needs and program target populations and services.		3.3		3.3	3.5	3.3	3.7
5. Request from the client appropriately signed releases when soliciting from or providing information to outside sources to protect client confidentiality.	4.2	4.0	4.0	3.9	4.5	4.4	4.1
6. Recognizing signs and symptoms that indicate a need to refer the client for additional professional assessment services when such assessment is outside the areas of the counsellor's expertise.		3.5		3.7	3.8	3.7	3.6
7. Develop a written diagnostic summary based on the results of separate assessments performed by an alcohol and drug abuse counsellor and/or a multi-disciplinary team including physical/chemical use/abuse history, psychological, psychiatric, social, spiritual, recreational, nutritional, educational, vocational and/or legal information to provide an integrated approach to diagnosis and treatment planning.					3.4	3.5	
8. Document ongoing treatment needs identified by regular assessments performed throughout the continuum of care and negotiate adjustments to the treatment plans to assure new treatment needs are addressed.		3.9					
9. Formulate mutually agreed upon goals, objectives, and treatment methods based upon assessment finding of the client's strengths, weaknesses, needs and problems for the purpose of directing a course of treatment.	3.6	4.0	3.5	3.6	3.6	3.5	3.6
10. Select, administer, score and interpret to clients the results of assessment instruments in order to provide accurate, standardized measurements of data relating to the clients' problems.					4.0		
11. Explain the purpose, rationale and methods associated with the assessment process to the client to assure understanding and compliance.				4.1	4.4		

AD = Administrator; PS = Program Supervisor; HC = Health Care Worker; CN = Counsellor; PW = Prevention Worker; OF = Office Worker; O = Other

Domain: COUNSELLING Tasks:	Current Self-Ratings by Respondent Category:						
	AD	PS	HC	CN	PW	OF	O
1. Establish rapport and trust with client, family members and related systems by providing a safe environment in order to facilitate self-exploration, disclosure, problem solving and interaction	4.1	3.9	4.2	3.9	3.9	4.1	4.0
2. In the initial counselling session, provide specific information to the client regarding the structure, expectations and limitations of the counselling process in order to promote a trusting relationship; and assist the client in decision-making regarding the treatment process.	4.1	4.0	4.2	4.0	4.1	4.1	4.1
3. Assist the client, family members and significant others in identification, clarification and expression of feelings by teaching, modelling and interacting in order to improve relationships, self-esteem and feeling recognition.	3.3	3.1	3.3	3.4	3.3	3.3	3.3
4. Provide individual therapy, using relevant and current client data with an appropriate therapeutic approach to meet the client's needs, problems, strengths and weaknesses to promote a quality recovery process.	3.8	3.6	3.8	3.8	3.8	3.8	3.9
5. Provide family therapy with client and/or significant others within a conducive setting to promote individual and system growth.							
6. Provide group therapy by modelling, directing and facilitating developmental stages within the group in order to promote growth.	3.3	3.3		3.3	3.5	3.2	
7. Identify group, purpose, rules, goals and membership criteria for group members through formal and informal means to facilitate interaction and communication.							
8. Assist clients, family members and significant others in establishing and maintaining new behaviours or changes in behaviour in order to minimize relapse through teaching, modelling and other counselling techniques.	3.4	3.1		3.3		3.4	3.4
9. Intervene in life crisis situations with client or significant others in order to prevent or cope with that crisis by utilizing needed resources and identifying and teaching new skills.	4.0	3.9	4.2	4.0	3.9	4.1	4.0
10. Provide care and follow-up appropriate to the client's needs after the initial phase is completed utilizing a variety of approaches.		3.1			3.2		
11. Assess ongoing issues and related progress with clients, family and significant others in order to promote growth through periodic review of goals and accomplishments.		3.3			3.6		
12. Provide current and accurate information and education to client, family members and significant others through written materials and other educational forums in order to prevent initiation or progression of alcoholism and drug dependency.	3.6	3.1		3.4	3.6	3.6	3.8

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Domain: COUNSELLING Tasks:	Current Self-Ratings by Respondent Category:						
	AD	PS	HC	CN	PW	OF	O
13. Acknowledge and respect cultural and life-style diversities as they relate to emotional, spiritual and physical health with all clients, family members and significant others to affirm differences through accepting attitudes and behaviours.	4.1	3.6	4.2	3.8	3.8	4.2	4.1
14. Assist clients, family, and significant others in the recognition of the role of defense mechanisms (especially denial and minimization) through confrontation, teaching and eliciting feedback, in order to further the recovery process.	4.1	3.9	4.2	4.0	3.9	4.1	4.0
15. Evaluate and assess through case reviews the effectiveness of the chosen counselling approaches and processes to ensure quality.	3.2	3.4	3.1	3.5	3.5	3.2	3.5

Domain: CASE MANAGEMENT Tasks:	Current Self-Ratings by Respondent Category:						
	AD	PS	HC	CN	PW	OF	O
1. Obtain and maintain information about community resources and services by establishing contact with other service providers in order to evaluate the appropriateness of referring the client.	3.4	3.6	3.4	3.5	3.6	3.4	3.6
2. Match the community resources with client needs in order to improve the effectiveness of treatment by paying particular attention to cultural and life-style characteristics of clients.	3.7	3.7		3.6	3.4	3.8	3.6
3. Verbally explain to the client the necessity for referral in order to ease the transition to other service providers.	3.5	3.5	3.6	3.4	3.9	3.4	3.8
4. Demonstrate proficiency in maintaining client record in accordance with prescribed standards to ensure thorough documentation.	3.5	3.4	3.7	3.4	3.5	3.5	3.5
5. Consult with supervisors, counsellors, professionals and/or other service providers by discussing one's own case to assure comprehensive, quality care for the client.	3.2	3.1	3.3	3.4	3.0	3.3	3.5
6. Present cases to other treatment team members in order to facilitate decision making and planning by using a written or oral method.	3.1	2.9	3.1	3.1	3.1	3.1	3.3
7. Assist other treatment team members by providing alternative input on their cases in order to develop comprehensive, quality care for the client.							
8. Verbally explain to the client the need for consultation and obtain written consent when needed in order to provide quality care.	3.9	3.6		3.9	3.8	4.1	4.0

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Domain: CASE MANAGEMENT Tasks:	Current Self-Ratings by Respondent Category:						
	AD	PS	HC	CN	PW	OF	O
9. Provide a program overview to the client by describing goals, objectives, rules and obligations in order to agree upon mutual expectations.	4.0	4.0		3.9	4.1	3.9	4.1
10. Provide education for the client about self-help groups by supplying appropriate information in order to encourage participation.		4.3		4.3	4.1		
11. Advocate for client's interests in targeted systems by negotiating plans in order to help resolve client's problems.						3.6	
12. Provide information through appropriate contacts with outside agencies in order to ensure adequate funding for services provided.				3.9			
13. Maintain through regular communication a network of community resources in order to enhance client's treatment.	4.0	3.9		4.1	4.0	4.1	4.2
14. Obtain evaluation through regular consultation with supervisors and peers in order to assess case management techniques.		3.3		3.3			

Domain: EDUCATION Tasks:	Current Self-Ratings by Respondent Category:						
	AD	PS	HC	CN	PW	OF	O
1. Provide relevant education to the client through formal and informal processes to introduce specific knowledge to support the recovery process.	3.5	2.8		2.8	2.8	3.5	3.5
2. Provide relevant education to family members and significant others through formal and informal processes to introduce specific knowledge to help support the recovery process.		3.1			3.2		
3. Provide alcohol and drug education to schools, service clubs, business, industry and labour, media representatives, political and community leaders and other significant persons to raise awareness and enhance community support.		3.2		2.9	3.5		
4. Provide drug and alcohol education and information to colleagues and other professionals via lectures, discussions and meetings to enhance professional exchange of information and ensure continuum of care for the client.		3.9		3.6	3.9		

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Domain: PROFESSIONAL RESPONSIBILITY Tasks:	Current Self-Ratings by Respondent Category:						
	AD	PS	HC	CN	PW	OF	O
1. Demonstrate ethical behaviours by adhering to established professional codes of ethics in order to maintain professional standards and safeguard the best interests of the client.	4.4	3.9		3.9	3.9	4.5	4.2
2. Adhere to federal, provincial and agency regulations regarding alcohol and other drug abuse treatment by following appropriate procedures to protect client rights.	4.1	3.7	4.2	3.8	3.8	4.2	4.1
3. Interpret and apply information from current counselling and alcohol and other drug abuse literature to improve client care and enhance professional growth.	3.5	3.3	3.6	3.3	3.7	3.4	3.7
4. Recognize the importance of individual differences by gaining knowledge about personality, cultures, life-styles and other factors influencing client behaviour in order to provide services that are sensitive to the uniqueness of the individual.	3.7	3.5	3.8	3.5	3.6	3.7	3.7
5. Develop and utilize a range of options to explore and discuss personal feelings and concerns about clients when these concerns may be interfering with the counselling relationship.	3.4	3.3	3.5	3.3	3.5	3.4	3.6
6. Conduct self-evaluations of professional performance applying ethical, legal and professional standards to enhance self-awareness and performance by identifying strengths and limitations.	3.1	3.0	3.1	3.0	3.0	3.2	3.1
7. Obtain appropriate continuing professional education by ongoing assessment of one's own training needs in order to promote professional growth.	3.2	3.0	3.1	3.0	3.3	3.2	3.3
8. Assess and participate in regular supervision and consultation sessions to facilitate clinical and administrative growth.	2.9	2.7	3.2	2.8	2.7	2.9	3.0
9. Develop and utilize strategies to maintain personal, physical and mental health in order to ensure professional effectiveness.	3.6	3.4	3.8	3.3	3.4	3.6	3.6
10. Establish and maintain good relations with civic groups, other professionals, government entities and the community in general through open communication and supportive involvement to expand community resources.	3.3	3.2	3.5	3.1	3.4	3.2	3.4

AD = Administrator; PS = Program Supervisor; HC = Health Care Worker; CN = Counsellor; PW = Prevention Worker; OF = Office Worker; O = Other

Appendix C

Component Analysis of Tasks Identified as High Priority Training Needs

The role delineation study used as a basis for this report breaks each task into both knowledge and skill areas. By examining these knowledge/skill breakdowns, it is possible to discover some specific training areas associated with each of the High priority training needs summarized in Table 19. For the purpose of the analysis below, High priority training needs identified only by office workers have been deleted.

Counselling Task 3: Assist the client, family members and significant others in identification, clarification, and expression of feelings by teaching, modeling and interacting in order to improve relationships, self-esteem and feeling recognition. *(High priority for all groups)*

Requires knowledge of:

1. family and environmental processes that inhibit or promote expression of feelings.
2. advantages and disadvantages of awareness and expression of feelings.
3. a range of feeling words.
4. assertiveness training.
5. issues related to boundary setting.

Requires skill in:

1. appropriate expression of feelings.
2. techniques to assist clients in learning appropriate expression of feelings.
3. techniques in self-esteem building.
4. assertiveness.
5. modeling appropriate boundary setting.

Counselling Task 4: Provide individual therapy, using relevant and current client data with an appropriate therapeutic approach to meet the client's needs, problems, strengths and weaknesses to promote a quality recovery process. *(High priority for all groups)*

Requires knowledge of:

1. determining therapy approach appropriate to client needs.
2. various therapy approaches relevant to alcohol and drug abuse counselling
3. criteria for evaluating alcohol and other drug use, misuse, abuse and dependence.
4. behaviour, patterns, and progressive stages of alcohol and other drug abuse/dependence.
5. states of intoxication, withdrawal, and long term effects of alcohol and other drug use.
6. adverse effects of combining various types of psychoactive drugs, including alcohol.
7. patterns and methods of misuse and abuse of prescribed and over-the-counter medications.
8. potential for cross addiction when psychoactive drugs are taken.
9. the consequences of the misuse of alcohol and drug dependency on family systems, significant others, and the community.
10. the dynamics of relapse.
11. interview processes, including objectives, stages, and techniques.
12. communication process.
13. use of feedback to the client.
14. methods of providing various forms of reinforcement to the client.
15. stages of grief and grief resolution.
16. the utility of defense mechanisms for the client and appropriate counselling approaches.
17. counsellor approach to client's defense mechanisms.
18. the various manifestations of denial as it relates to the client's use, misuse, abuse and dependence on alcohol and/or other drugs.
19. the range of self-help fellowship available to the community.
20. the treatment planning process.
21. methods of responding to a client in crisis.
22. human needs and motivation.
23. phases of treatment and client responses (i.e., crises, impasses, plateaus, resistance, etc.)

24. a range of productive coping skills and problem solving techniques.
25. behavioural contracting.
26. cognitive and behavioural changes to support recovery.
27. transference and countertransference issues.

Requires skills in:
1. identifying and interpreting verbal and non-verbal behaviour.
2. furthering responses or eliciting information and feedback.
3. utilizing appropriate self-disclosure.
4. analysing data to determine therapy approach.
5. selecting and providing appropriate therapy approaches.
6. therapeutic communication (i.e., reflecting, clarification, paraphrasing, reframing, confrontation, etc.)
7. observing and responding to unstated feelings.
8. giving both positive and negative feedback.
9. focusing on the here and now.
10. demonstrating acceptance of the individual while confronting the non-productive behaviours.
11. teaching and modeling problem-solving skills and options.
12. summarizing and checking for accuracy.
13. recognizing and responding to congruency and non-congruency in the therapy process.
14. determining relevant task assignments appropriate to different therapeutic stages.
15. appropriate empathic response.
16. recognizing client resistance.
17. differentiating between facts, feelings and impressions.
18. identifying inconsistencies in values and behaviour.
19. exploration of options, attitudes, and new behaviours.

Counselling Task 6: Provide group therapy by modeling directing, and facilitating developmental stages within the group to promote growth. *(High priority for administrators and counsellors)*

Requires knowledge of:
1. different types of groups, their purposes, functions, and parameters.
2. varying group leader roles and styles.
3. individual behaviour as it impacts on group process.
4. therapeutic factors in group therapy (universality, altruism, collective family experience).
5. theories related to group membership and rules as related to group purpose.
6. basic tasks in creation and maintenance of a group.
7. impact on group factors such as size, frequency, duration, and admission of new members.
8. developmental stages of groups.
9. a variety of group techniques, their purposes, and consequences.
10. criteria for evaluating alcohol and other drug use, misuse, abuse and dependence.
11. behaviour, patterns, and progressive stages of alcohol and other drug abuse/dependence.
12. states of intoxication, withdrawal, and long term effects of alcohol and other drug use.
13. adverse effects of combining various types of psychoactive drugs, including alcohol.
14. patterns and methods of misuse and abuse of prescribed and over-the-counter medications.
15. potential for cross addiction when psychoactive drugs are taken.

16. differences found in special populations (e.g., cultural, ethnic, and racial minorities; handicapped populations; special populations identified by age, gender, sexual orientation, etc.) and how differences affect assessment and response to treatment.
17. historic and generational influences on alcohol and drug abuse/dependence (i.e., family of origin, ACOA issues, etc.)
18. consequences of the misuse of alcohol and drug dependency on family systems, significant others, and the community.
19. how peer influence encourages or discourages alcohol and/or other drug use, abuse, or dependence.
20. the normal range of affect.
21. the dynamics of relapse.
22. communication process.
23. the use of feedback to the client.
24. methods of providing various forms of reinforcement to the client.
25. stages of grief and grief resolution.
26. the utility of defense mechanisms for the client and appropriate counselling approaches.
27. counsellor approach to client's defense mechanisms.
28. the various manifestations of denial as it relates to the client's use, misuse, abuse and dependence on alcohol and/or other drugs.

Requires skills in:
1. preparing the chemically dependent person for group.
2. dealing with membership problems (turnover, dropout).
3. establishing and environment to support trust among group members.
4. developing cohesiveness among group members.
5. communicating differences between group therapy and twelve step groups.
6. utilizing conflict in group for individual and group growth.
7. dealing with group behaviours such as subgrouping, conflict, and self-disclosure.
8. culture building in group.
9. focusing on interaction among group members with attention to the here and now.
10. making process comments appropriate to the developmental stage of the group.
11. timing of interventions in interactions.
12. termination of the counselling process with the group or an individual member.

Counselling Task 15: Evaluate and assess through case reviews the effectiveness of the chosen counselling approaches and processes to ensure quality control. *(High priority for health care workers only)*

Requires knowledge of:
1. various therapy approaches relevant to alcohol and other drug abuse counselling.
2. evaluation techniques to determine therapy effectiveness.
3. multi-disciplinary team functions.
4. continuum of care.
5. referral rationale for group counselling and individual counselling.
6. the treatment planning process.

Requires skills in:
1. case review and analysis of client data.
2. facilitating a multi-disciplinary team process.

Case Management Task 1: Obtain and maintain information about community resources and services by establishing contact with other service providers in order to evaluate the appropriateness of referring the client. *(High priority for administrators and health care workers, medium priority for all other groups)*

Requires knowledge of:

1. skills/services provided by other professionals.
2. how to network with other professionals.
3. how to interpret and integrate consultation results.
4. oral/written communication.
5. follow-up process with referral sources.
6. differences found in special populations (e.g., cultural, ethnic, and racial minorities; handicapped populations; special populations identified by age, gender, sexual orientation, etc.) and how differences affect assessment and response to treatment.
7. the relationship between alcohol and other drug abuse and various cultures, values, and lifestyles.
8. the continuum of care.
9. services provided within the community and necessary referral information.
10. the range of self-help fellowship available to the community.

Requires skills in:

1. assessing client's needs and matching them to outside resources.
2. networking/interacting with outside resources.
3. identifying personal and agency limitations.

Case Management Task 5: Consult with supervisors, counsellors, professionals and/or other service providers by discussing one's own case to assure comprehensive, quality care for the client. *(High priority for administrators, health care workers and prevention workers; medium priority for all other groups)*

Requires knowledge of:

1. agency's policies regarding case consultation.
2. professional scope of practice.
3. one's own strengths and limitations.
4. the importance of soliciting peer input.
5. legal confidentiality requirements.
6. professional terminology.
7. how to develop and present a comprehensive case structure.

Requires skills in:

1. making clear, concise, oral case presentations.
2. assembling and analysing data for case consultation.
3. active and empathic listening.
4. interpreting written reports of other professionals.
5. observing and responding to feedback from other professionals.
6. identifying and utilizing sources of supervision and consultation.

Case Management Task 6: Present cases to other treatment team members in order to facilitate decision making and planning by using a written or oral method. *(High priority for administrators, supervisors, health care workers and prevention workers; medium priority for counsellors)*

Requires knowledge of:

1. how to write/present/develop a case presentation.
2. professional terminology.
3. the value of case consultation.
4. personal/professional strengths and limitations.
5. the continuum of care.

Requires skills in:

1. presenting cases in a clear, concise manner.
2. writing clear, comprehensive case studies.
3. evaluating peers' feedback relative to your own knowledge of the case.
4. selecting/adapting treatment approaches to the feedback received from others.
5. recognizing peers' strengths and limitations.

Education Task 1: Provide relevant education to the client through formal and informal processes to introduce specific knowledge to support the recovery process. *(High priority for program supervisors, counsellors and prevention workers)*

Requires knowledge of:

1. stress management
2. positive coping skills
3. criteria for evaluating alcohol and other drug use, misuse, abuse and dependence.
4. behaviour, patterns, and progressive stages of alcohol and other drug abuse/dependence.
5. states of intoxication, withdrawal, and long term effects of alcohol and other drug use.
6. adverse effects of combining various types of psychoactive drugs, including alcohol.
7. patterns and methods of misuse and abuse of prescribed and over-the-counter medications.
8. potential for cross addiction when psychoactive drugs are taken.
9. trends in street and designer drugs.
10. the effects of alcohol and other drug use/abuse on nutrition and proper eating habits.
11. significance of diagnostic reports from laboratory studies (e.g., blood, urine, saliva, EEG tests).
12. sexually-transmitted diseases and their relation to alcohol and other drug abuse.
13. differences found in special populations (e.g., cultural, ethnic, and racial minorities; handicapped populations; special populations identified by age, gender, sexual orientation, etc.) and how differences affect assessment and response to treatment.
14. historic and generational influences on alcohol and drug abuse/dependence (i.e., family of origin, ACOA issues, etc.)
15. consequences of the misuse of alcohol and drug dependency on family systems, significant others, and the community.
16. how peer influence encourages or discourages alcohol and/or other drug use, abuse, or dependence.
17. the relationship between alcohol and other drug abuse and various cultures, values, and lifestyles.
18. the effects of the psychoactive drugs on affective states.

19. the relationship between alcohol and other drug use, abuse, and dependence and sexual function.
20. addiction substitution.
21. correlation between alcohol and other drug abuse/dependence and specific mental disorders such as mood disorders, anxiety disorders, and schizophrenia.
22. correlation between alcohol and other drug abuse/dependency and childhood trauma, including physical, emotional, and sexual abuse.
23. signs and symptoms of mental and personality disorders and implications for treatment and referral.
24. the normal range of affect.
25. signs, symptoms, and patterns of domestic violence.
26. sexual dysfunctions, including compulsive sexual behaviours.
27. risk factors that relate to potential suicide, homicide, family violence, self injury, and other violent and aggressive behaviours.
28. the dynamics of relapse.
29. expected rates of progress in recovery.
30. communication process.
31. the use of feedback to the client.
32. stages of grief and grief resolution.
33. the various manifestations of denial as it relates to the client's use, misuse, abuse, and dependence on alcohol and/or other drugs.
34. the continuum of care.
35. services provided within the community and necessary referral information.
36. the range of self-help fellowship available to the community.
37. the stages of human development.
38. human needs and motivation
39. family systems.
40. the services available to clients in the areas of child care and parenting, especially as they affect access to treatment and other services.
41. requirements regarding the mandatory reporting of child abuse.
42. federal, provincial, and local laws related to alcohol and drug use, possession, distribution, and behaviour.

Requires skills in:

1. reading and interpreting professional literature.
2. organizing information.
3. time management.
4. oral and written presentation of information.
5. conveying respect for cultural and lifestyle diversity.
6. mediating conflict.
7. obtaining, organizing, and analysing feedback.
8. explaining the rationale for decisions affecting confidentiality.
9. explaining the role and purpose of education in the treatment process.

Education Task 2: Provide relevant education to family members and significant others through formal and informal processes to introduce specific knowledge to help support the recovery process. *(High priority for prevention workers)*

Requires knowledge of:

1. positive coping skills.
2. criteria for evaluating alcohol and other drug use, misuse, abuse and dependence.

3. behaviour, patterns, and progressive stages of alcohol and other drug abuse/dependence.
4. states of intoxication, withdrawal, and long term effects of alcohol and other drug use.
5. adverse effects of combining various types of psychoactive drugs, including alcohol.
6. patterns and methods of misuse and abuse of prescribed and over-the-counter medications.
7. potential for cross addiction when psychoactive drugs are taken.
8. trends in street and designer drugs.
9. the effects of alcohol and other drug use/abuse on nutrition and proper eating habits.
10. significance of diagnostic reports from laboratory studies (e.g., blood, urine, saliva, EEG tests).
11. sexually-transmitted diseases and their relation to alcohol and other drug abuse.
12. differences found in special populations (e.g., cultural, ethnic, and racial minorities; handicapped populations; special populations identified by age, gender, sexual orientation, etc.) and how differences affect assessment and response to treatment.
13. historic and generational influences on alcohol and drug abuse/dependence (i.e., family of origin, ACOA issues, etc.)
14. consequences of the misuse of alcohol and drug dependency on family systems, significant others, and the community.
15. how peer influence encourages or discourages alcohol and/or other drug use, abuse, or dependence.
16. the relationship between alcohol and other drug abuse and various cultures, values, and lifestyles.
17. the effects of the psychoactive drugs on affective states.
18. the relationship between alcohol and other drug use, abuse, and dependence and sexual function.
19. addiction substitution.
20. correlation between alcohol and other drug abuse/dependence and specific mental disorders such as mood disorders, anxiety disorders, and schizophrenia.
21. correlation between alcohol and other drug abuse/dependency and childhood trauma, including physical, emotional, and sexual abuse.
22. signs and symptoms of mental and personality disorders and implications for treatment and referral.
23. the normal range of affect.
24. signs, symptoms, and patterns of domestic violence.
25. sexual dysfunctions, including compulsive sexual behaviours.
26. risk factors that relate to potential suicide, homicide, family violence, self injury, and other violent and aggressive behaviours.
27. the dynamics of relapse.
28. expected rates of progress in recovery.
29. communication process.
30. the use of feedback to the client.
31. stages of grief and grief resolution.
32. the continuum of care.
33. services provided within the community and necessary referral information.
34. the range of self-help fellowship available to the community.
35. the stages of human development.
36. human needs and motivation
37. family systems.
38. the services available to clients in the areas of child care and parenting, especially as they affect access to treatment and other services.
39. requirements regarding the mandatory reporting of child abuse.
40. federal, provincial, and local laws related to alcohol and drug use, possession, distribution, and behaviour.

Requires skills in:

1. reading and interpreting professional literature.
2. organizing information.
3. time management.
4. oral and written presentation of information.
5. conveying respect for cultural and lifestyle diversity.
6. mediating conflict.
7. obtaining, organizing, and analysing feedback.
8. explaining the rationale for decisions affecting confidentiality.
9. explaining the role and purpose of education in the treatment process.

Education Task 3: Provide alcohol and drug education to schools, service clubs, business, industry and labour, media representatives, political and community leaders, and other significant persons to raise awareness and enhance community support. *(High priority for counsellors)*

Requires knowledge of:

1. community resources in alcohol and drug abuse treatment.
2. the effects of addiction on society and the family.
3. chemical dependency problems in he community.
4. criteria for evaluating alcohol and other drug use, misuse, abuse and dependence.
5. behaviour, patterns, and progressive stages of alcohol and other drug abuse/dependence.
6. states of intoxication, withdrawal, and long term effects of alcohol and other drug use.
7. adverse effects of combining various types of psychoactive drugs, including alcohol.
8. patterns and methods of misuse and abuse of prescribed and over-the-counter medications.
9. potential for cross addiction when psychoactive drugs are taken.
10. trends in street and designer drugs.
11. effects of blood alcohol content (BAC) on behaviour and state of arousal.
12. legal limits on blood alcohol content (BAC).
13. the effects of alcohol and other drug use/abuse on nutrition and proper eating habits.
14. significance of diagnostic reports from laboratory studies (e.g., blood, urine, saliva, EEG tests).
15. sexually-transmitted diseases and their relation to alcohol and other drug abuse.
16. differences found in special populations (e.g., cultural, ethnic, and racial minorities; handicapped populations; special populations identified by age, gender, sexual orientation, etc.) and how differences affect assessment and response t[illegible]eatment.
17. historic and generational influences on alcohol and drug abuse/dependence (i.e., family of origin, ACOA issues, etc.)
18. consequences of the misuse of alcohol and drug dependency on family systems, significant others, and the community.
19. how peer influence encourages or discourages alcohol and/or other drug use, abuse, or dependence.
20. the relationship between alcohol and other drug abuse and various cultures, values, and lifestyles.
21. the effects of the psychoactive drugs on affective states.
22. the relationship between alcohol and other drug use, abuse, and dependence and sexual function.
23. addiction substitution.
24. correlation between alcohol and other drug abuse/dependence and specific mental disorders such as mood disorders, anxiety disorders, and schizophrenia.

25. correlation between alcohol and other drug abuse/dependency and childhood trauma, including physical, emotional, and sexual abuse.
26. signs and symptoms of mental and personality disorders and implications for treatment and referral.
27. the normal range of affect.
28. the dynamics of relapse.
29. expected rates of progress in recovery.
30. communication process.
31. the various manifestations of denial as it relates to the client's use, misuse, abuse, and dependence on alcohol and/or other drugs.
32. the continuum of care.
33. services provided within the community and necessary referral information.
34. the range of self-help fellowship available to the community.
35. the stages of human development.
36. human needs and motivation
37. family systems.
38. the services available to clients in the areas of child care and parenting, especially as they affect access to treatment and other services.
39. requirements regarding the mandatory reporting of child abuse.
40. federal, provincial, and local laws related to alcohol and drug use, possession, distribution, and behaviour.

Requires skills in:

1. reading and interpreting professional literature.
2. organizing information.
3. time management.
4. oral and written presentation of information.
5. conveying respect for cultural and lifestyle diversity.
6. mediating conflict.
7. obtaining, organizing, and analysing feedback.
8. explaining the rationale for decisions affecting confidentiality.
9. explaining the role and purpose of education in the treatment process.

Professional Responsibility Task 6: Conduct self-evaluations of professional performance applying ethical, legal and professional standards to enhance self-awareness and performance by identifying strengths and weaknesses. *(High priority for administrators, health care workers, counsellors, and prevention workers; medium priority for program supervisors)*

Requires knowledge of:

1. the importance of self-evaluation.
2. one's personal strengths and limitations.
3. one's professional strengths and limitations.
4. intrapersonal dynamics.
5. legal issues and related professional standards.
6. ethical standards which apply to alcohol/drug abuse counselling.
7. professional standards which apply to alcohol/drug abuse counselling.
8. the consequences of disregarding proper professional standards.
9. self-evaluation techniques.
10. regulatory guidelines and restrictions relating to alcoholism/drug treatment and counselling.

Requires skills in:

1. developing professional goals and objectives.
2. interpreting and applying ethical, legal, and professional standards.
3. recognizing personal strengths and limitations.
4. utilizing self-assessment for personal and professional growth.
5. eliciting and utilizing feedback from colleagues and supervisors.

Professional Responsibility Task 8: Assess and participate in regular supervision and consultation sessions to facilitate clinical and administrative growth. *(High priority for all groups)*

Requires knowledge of:

1. the importance of regular assessment of professional skills and development.
2. clinical supervision models.
3. the value of consultation to enhance personal and professional growth.
4. strengths and limitations of one's own work setting.
5. how to present client cases to supervisor or other professionals.
6. how to identify needs for clinical or technical assistance.
7. interpersonal dynamics and needs.

Requires skills in:

1. identifying one's own professional progress and limitations.
2. openly communicating need for assistance.
3. organizing client information for presentation to others.
4. focusing on current, relevant issues.
5. accepting both constructive criticism and positive feedback.
6. soliciting feedback from others.

Appendix D

Focus Group Report

REPORT OF FOCUS GROUP

OCTOBER 28, 1993

submitted by
Consultant Facilitators

ADRIENNE BURK

ANDREA KASTNER

I. BACKGROUND AND INTRODUCTION

This report summarizes discussion and information gathered from selected supervisors and administrators working in various Alcohol and Drug services programs in B.C. These participants, hereinafter referred to as the "Focus Group", met between 2:45-5:00 PM Thursday, October 28, 1993, immediately following a meeting of the full Advisory Committee Project. The team managing the entire Project had invited to the Focus Group those on the Advisory Committee "who are supervisors, who have worked in a supervisory capacity, or who believe they can react from a supervisor's point of view." The Project team indicated to participants and to external facilitators enlisted for this meeting that the purpose of this discussion was "for supervisors on the Committee and those who have input to give [to determine] what supervisors think are the minimum requirements to work in each [of several treatment] setting[s]." This information was intended to augment data, gathered through a mailed questionnaire, on workers' own views about qualifications needed to do their work.

The external facilitators understood that the goal of the overall Advisory Committee Project was to conduct a training needs analysis based on the actual practice and realities of the field of Alcohol and Drug abuse prevention and treatment. As such, we elected to use methods designed to enhance discussion, and, especially, to ground comments in the realities of each of the physical settings for which participants were trying to determine minimum specific educational requirements.

Given the proximity of the full Project Advisory Committee meeting and this more in-depth Focus Group, the facilitators elected to employ very deliberately different and somewhat unusual methods to underscore the change in intentions for the Focus Group. The first of these included a specific "role switch" for participants which the facilitators sought to make explicit before beginning the substantive discussions. Participants were asked shift from "official viewpoints" to more "looking with insight" in their comments.

In addition, the facilitators elected to use a highly visual method of facilitation, in which participants' actual words, imagery, and sense of emphasis is publicly recorded on large sheets of paper. This method allows participants immediate access to add to or edit interpretations of their words. It also encourages participants to view their knowledge within a larger "picture" or structure of perspectives. This, in turn, facilitates a more comprehensive, yet still focused understanding of a complex task. This facilitative technique, known as "graphic facilitation" involves some prepared charts as well. For this Focus Group, these included those shown at the right, as well as one outlining the explicit purpose of the Focus Group, and an Agenda specifying steps towards achieving that purpose.

"Official Viewpoint"

* responsible to constituency
* must stay within role
* expected to convince, not discuss

"Looking With Insight"

* based on personal experiences
* drawn from "seasoned" practice
* sharing deeper understanding

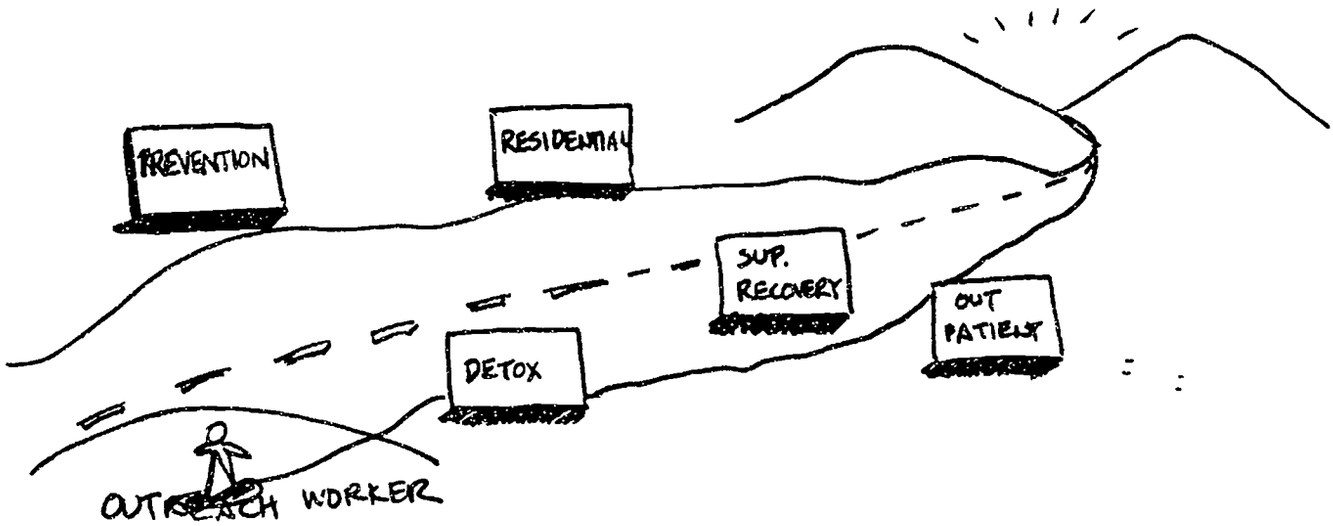
The facilitators felt it imperative, first, to remind participants that the most meaningful discussion of qualifications would come from within a strongly associative sense of actual practice settings. As such, the facilitators pre-prepared some charts of each of four settings. These were introduced sequentially, and filled in from the actual detailed discussions generated by participants concerning the current and possible future conditions of actual practice in that setting. After these were complete, the participants insisted on inclusion of at least two other types of service in order to meaningfully represent current provision in the field. Following these discussions, the facilitators proceeded with the second task of the meeting: identifying specific minimum requirements for qualifications for each of several types of workers to work effectively within these six settings. Several lists of qualifications emerged, which are delineated below.

The format of this report follows closely the actual Focus Group. First, there appears the detailed descriptions of the six settings; second, there follows a summary of minimum educational requirements to work within the jobs and settings listed; and finally, there are several facilitators' observations resulting from the meeting.

A final introductory note: present for the Focus Group were: (Participants) Juanita Arthur, Brian Butcher, Helen DeGroot, Bill Downie, Carol-Ann Dwyer, Elaine Hooper, Charlotte Mallory, Eleanor May, Sherry Mumford, and Don Potkins; (Project Team) Debi Black, Marg Penney, Inga Thomson, and Gloria Wolfson; (External Facilitators) Adrienne Burk and Andrea Kastner.

II. "SNAPSHOTS" OF SERVICE PROVISION

Four types of service settings had been identified by the Project Team. On the basis of this information, the facilitators represented them on a "map". The two additional service settings later included by the participants also appear:



The facilitators asked two key questions to generate roughly equivalent "snapshot" displays of service provision within each setting:

1) What kinds of clients use this type of service? Any key characteristics?
2) What specific services does this setting offer?

As in keeping with the guidelines of graphic facilitation, the exact phrases, imagery, and comments used by the participants appear below. Where abbreviations or contexts are known, they have been spelled out.

1. PREVENTION

Clients: seniors, students, staffs, parents, other professionals. Prevention workers make a point of going *to* clients.

Services:
- Pregnancy Outreach
- Education (e.g. Life Skills, Self-Esteem, Making Choices, and Substance Information) Note: prevention programs may be set in elementary schools.
- Counseling in Schools (peer counselors, services for kids whose parents are abusers)
- Community Development (e.g. "Counterattack", encouraging community responsibility, liaising with others, e.g. S.P.O.'s, Financial Assistance Workers, Police, Public Health, Mental Health, and Ministry of Social Service.)

2. DETOX

Clients: generally adults (19+; most aged between 25-45); mostly physically debilitated; many with legal problems; members of all socio-economic and cultural categories; increasingly, women; many multi-service users, many with multiple drug addiction (O.T.C., prescriptions, cocaine, valium, marijuana, alcohol, codeine) and multiple problems, including sexual and psychiatric abuse. Clients *must* be referred- not "anyone who snows up at the door".

Services: There are centres for both voluntary and involuntary clients; there can be medical, non-medical, and psychiatric referrals. Length of stay varies between three hours and a few weeks, but averages 5 (five) days. Regardless of these variables, the stages of detoxification always begin with an attempt at stabilization and crisis management. Next follows a period designed to give the client safety, structure, and information, including an orientation to treatment, an assessment and referral, an introduction to 12-step programs and other types of support, and preparation and implementation of an individualized treatment plan.

3. RESIDENTIAL

Clients: generally adults (19+) falling within the ADP criteria, needing to be de-toxed, must be referred (from ADP, Dr.'s, Case Managers, Employee Assistance Programs, prison); there are significant differences between various centres- some are only single gender, some co-ed, some for families, or aboriginals, or only youth, etc. They are "philosophy driven" and cater to specialized populations.

Services: These centres structure services based upon an understanding that clients live within an entire pattern of abuse; therefore, treatment is generally holistic by design, involving physical safety, a substance-free environment, a healthy life-style, good food, and intensive group therapy. Stays are limited to 4-6 weeks. Centres strive to match clients with appropriate programs, and cater to physical, emotional, mental, and spiritual needs. Note: These sites tend to be concentrated in urban, rather than rural areas.

4. OUTPATIENT

Clients: open to "everybody", but in practice, generally focused on English speaking adults (22+). These centres see their clients as "the community", and target about a third of their efforts towards prevention. They see a need for more outpatient services for youth (6-19) and young adults (19-22).

Services:
- Counseling- This practice is targeted to the "substance affected", including substance abusers, "misusers", "co-laterals", "co-dependents", "adult children" of abusers, and seekers of free counseling services. Specific counseling is matched to clients, e.g. families, individuals, groups, couples, youth, or seniors.
- Assessment and Referral
- Prevention Education

5. OUTREACH WORKER

Clients: Always very high-risk, multi-agency users, crisis driven, often IV drug users, Fetal Alcohol Syndrome, transient and unconnected with family or community, often dual diagnosis, revealing multiple needs and multiple abuse patterns. These people are not functioning well enough for supportive recovery environment. Outreach workers go to them, wherever they may be.

Services:
- Offer Direction, Support, Assessment, Referral
- Teach Survival Skills
- Distribute Condoms/Needles and Emergency Help
- Train Other Professionals
- Create Linkage (to family, recreation, healthy alternatives)

Outreach workers are described as creative, tolerant, mobile, courageous, flexible, multiply-talented, and not "suit or tie types." They may be ex-users themselves, but regardless, they operate with a near "missionary" level of commitment. They have enormous credibility, with the clients, and the police and other ADP agencies' personnel.

6. SUPPORTIVE RECOVERY

Clients: Usually de-toxed (at least through acute phase), P.A.W.s, unemployed adults without identified support, often from the street addictive community. These clients have addiction problems as opposed to mental ones. They are admitted to gender-specific centres. In some cases clients must be connected to outpatient clinics.

Services:
- Halfway between Detox and Residential
- 12-Step/ Philosophical Base

These are variable services within ADP. Some of these centres are also funded by The Ministry of Social Services for specific, individual clients, but many are not. Some are designed as long-term environments (3-6 months), but others have a maximum 30 day stay. Often, these centres are run by a skeleton, underpaid staff of ex-users. (The Peat Marwick study mentioned by Don contains detailed information of these centres.)

III. DISCUSSION OF QUALIFICATIONS

Animated discussion led to consensus among attendees of the following specific minimum requirements for particular jobs/particular settings:

Prevention Workers

* 4 year BA

* Understanding of how to structure education programs

NB: The reality is that these workers often have less formal educational qualifications than others within ADP.

Counselors (in residential, outpatient, detox, and supportive-recovery centres)

* In-depth framework for understanding substance abuse (including conceptual, physical, psychological, and social contexts)

* BA in social science, with extensive experience (5-7 yrs.) in field OR
MA in social science with 2-5 yrs. in counseling in addictions within a mental health setting

* Generic counseling skills

* Appreciation of current abuse crisis ("not as a 'moral issue'- as a real one")

* Understanding of how to structure education programs

NB: In **Residential** Centres, these workers need SOFA and CPR training
In **Supportive-Recovery** Centres, there is much greater openness to educational "equivalencies". Equivalent qualifications can include such experience as 2 years of being in recovery, 1 year work experience in other residential settings, a Licensed Practical Nurse or a 1-2 year social service certificate, or 2 years in some kind of "addiction and support" environment. Generally, it was accepted agencies could train individuals "in the substance field" if they possessed other relevant knowledge and experience .

Health Care Workers (in detox and residential settings)

Although the Focus Group did not explicitly consider specific minimum requirements for these positions, in general discussion, the group indicated that the type of training and experience mentioned regarding equivalencies within Supportive Recovery Centres would be appropriate to Health Care Workers as well. (See **NB** under Counselors, Supportive Recovery Centres).

Administrators

* In-depth framework for understanding substance abuse

* BA or MA as listed under "counselors". NB: Would consider MBA, MPA, MPH ONLY IF candidate also had clinical supervision and Human Services experience.

* Generic counseling skills; should have done counseling or prevention work

* Training in clinical supervision, team management, and organizational skills.

* Experience in working with a board, working with community (defined as ADP community, geographical community, and other services community), working with program design and evaluation, and working with funding agencies, including ministries

* Experience in Labor Relations

* Public speaking skills; excellent verbal and written communication skills

IV. FACILITATORS' OBSERVATIONS

There were several points in discussion which, on reflection, may indicate points where further clarification is crucial to the development of a meaningful and appropriate curriculum. Additionally, there are indications from the "graphic minutes" where either the participants assumed or at least did not explicitly consider aspects of certain kinds of educational training. It is therefore our strong recommendation that the Project Team address the points listed below, as to the implications they hold for emerging "minimum specific requirements" for all the types of settings and job definitions considered.

Firstly, the facilitators note that in the discussions around formal education requirements, participants were not able to investigate assumptions about the *precise content* of formal education programs such as Bachelors and Masters programs identified by participants as minimum requirements. What do supervisors and administrators know about existing curricula of these programs and exactly how courses do (or do not) appropriately prepare workers for the field? What is their basis for supporting the identified formal qualifications? The graphic minutes show no mention, for instance, of the particular Bachelors of Social Work, even though that degree requires counseling, social problem theory, and practice, whereas other BA's do not. Is this simply an oversight, or an assumption?

Secondly, the facilitators note that the exploratory discussion of two additional, previously unidentified settings as critically important elements within the ADP field seriously jammed an already very tight agenda. The resulting time restraints limited the facilitators in developing a deeper exploration of participants' views about a "values and attitudes" dimension of qualifications for practice in the ADP field. This omission is significant; participants repeatedly referred obliquely to just such a dimension, and it cannot be assumed that course work in all BA or MA programs or experience in the field necessarily develops this dimension. Neither can the Project Team hope it will be clarified by the findings of the Dacum-type task inventories.

Thirdly, it was clear from the discussion that the actual shape of the ADP field is due to change dramatically, in terms of the types of services provided, ADP's criteria for clients, and the funding of various types of services and institutions. Although this aspect was not originally included in the scope of the Focus Group agenda, in the meeting it became clear that such changes will affect both training for, and operating realities in, both administrative and clinical capacities. Again, any meaningful, standardized curriculum should attend to these impending changes.

The fourth observation parallels this administrative change with changes in the service populations. Among the Focus Group participants, there seemed to be a consensus that the actual client group itself is changing. They mentioned an increase in the number of women clients, and a huge incidence of multi-agency, multiple abuse, and dual diagnosis clients. Participants also shared their sense that the field already is inadequately addressing the needs of non-ambulatory and non-English speaking clients, even as cultural sensitivity is seen as increasingly

important in treatment. As facilitators, we encourage an orientation that emphasizes knowledge of cultures and culturally sensitive skills for all workers in the field, rather than solely the recruitment of minority culture or physically disabled workers into the field. Again, if such an orientation is shared by practitioners, it may have significant impact upon the "minimum specific requirements" for effective work in the ADP field.

Finally, as the clients are increasingly presenting dual diagnosis a d HIV+ status, there are immediate and important implications for the experience and training required to address clients' treatment needs. Case management may soon alter from a handful of professionals discussing a client, to three to four times that number of professional viewpoints and recommendations. Clearly, clinical supervision and relationships between agencies will be affected. For HIV+ clients, the paradigm of treatment is radically different, and will necessarily involve extensive familiarity with death and dying issues. Many practitioners shared with us before and after the meeting that this experience is simply not part of the repertoire of skills and training even within the general "framework" of addiction identified during the meeting. Also, it is not currently a featured part of training in counseling skills. Some speculated that, for this reason, the "outreach workers" they identified during the meeting are in fact, the ones doing the most credible and meaningful substance abuse work at this time ("real practice in the real world"). Clearly, this observation warrants more exploration.

In summary, we feel that the Focus Group discussions referenced here produced rich descriptions, animated discussion, and vivid evocation of the real practice of the ADP field. Even given the difficulties of limited time, the facilitators believe that the initial technique of "grounding" participants in the roles of "seasoned practitioners" within a variety of settings allowed the ensuing discussions to yield genuine substance and important detail. The considerations mentioned in this final section, if addressed in an equally substantive and exploratory way in the Project Team's continuing work with the Project, will, we are sure, lend genuine value and impressive reality to any overall recommendations for curriculum and training for effective workers within the ADP field.